Astoria Healthcare Limited

Vicarage Farm Nursing Home

Inspection report

139 Vicarage Farm Road
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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 2 May 2018 and was unannounced. At our last inspection on 3 May 2016 we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Vicarage Farm nursing home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Vicarage Farm Nursing Home provides accommodation and nursing for up to 59 people in one adapted building split over two floors, each of which have separate adapted facilities. There is a seven bedded high dependency unit on the ground floor which specialises in providing care to people living with advanced dementia.

At the time of our inspection there were 59 people living at the home. The home is managed and run by Astoria Healthcare Limited, a private organisation. The organisation does not have any other services.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were systems and processes in place to protect people from the risk of harm. There were enough staff on duty to meet people's needs.

Checks were carried out during the recruitment process to ensure only suitable staff were employed.

There were arrangements in place for the safe management of people's medicines and regular checks were undertaken.

The service was clean and had effective systems to protect people by the prevention and control of infection.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

The provider was aware of their responsibilities and had acted in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People's nutritional and healthcare needs had been assessed and were met.

People were supported by staff who were suitably trained, supervised and appraised.

Staff were caring and treated people with dignity and respect. Care plans addressed each person's individual needs, including what was important to them, and how they wanted to be supported.

People were involved in undertaking activities of their choice. People were cared for in a way that took account of their diversity, values and human rights.

People's end of life wishes were discussed and recorded.

People living at the home, their relatives and stakeholders told us that the management team was approachable and supportive. People and their relatives were supported to raise concerns and make suggestions about where improvements could be made.

The provider had effective systems in place to monitor the quality of the service and ensure that areas for improvement were identified and addressed.

The registered manager kept themselves informed of developments within the social care sector and cascaded important information to the rest of the staff team.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains safe.	Good
Is the service effective? The service remains effective.	Good
Is the service caring? The service remains caring.	Good
Is the service responsive? The service remains responsive.	Good
Is the service well-led? The service remains well-led.	Good

Vicarage Farm Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place on 2 May 2018 and was unannounced. The inspection was carried out by one inspector, a nurse specialist advisor and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the service, including notifications we had received from the provider and the findings of previous inspections. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. The registered manager was in the process of completing a Provider Information Return (PIR) at the time of our inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our visit, we spent some time observing staff delivering care and support to people, to help us understand people's experiences of using the service. Our observations included using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us.

We also looked at records, including care plans for 14 people, six staff records and records relating to the management of the service. We spoke with eight people who used the service, nine relatives, 14 staff including the registered manager, the operations manager, two staff nurses, two team leaders, six care staff, one kitchen staff and one activity coordinator. We also spoke with a healthcare professional who was visiting at the time of our inspection. Following our inspection, we received feedback from three healthcare

professionals from the Richmond and Hounslow Community Healthcare NHS Trust.

Good

Is the service safe?

Our findings

People we spoke with indicated they felt safe living at Vicarage Farm nursing home. One person told us, "I am getting good care here, everything is very good, sorted out nicely. Definitely I am safe here, no complaints. When I ring the call bell, they come as soon as they can." Relatives agreed and said, "I find the nursing home adequate and providing excellent care", "[Family member] is safe here" and "[Family member] is safe. Nurses and care assistants are outstanding." One healthcare professional echoed this and said, "I think people are safe. I have seen there is always care staff in the communal lounge looking after clients there" and another stated, "I believe that people at Vicarage Farm are safe in that staff seem to take care and pay attention to people's safety, to those in wheelchairs and people who have mobility issues. This was evident on the two recent visits."

Arrangements were in place for the management of people's medicines. We checked medicines storage, medicines administration record (MAR) charts, and medicines supplies. All prescribed medicines were available at the service and were stored securely in a locked medicines trolley (within a locked room). This assured us that medicines were available at the point of need and stored securely.

Medicines were administered by nurses who had been trained in medicines administration and there were regular medicines audits. People received their medicines as prescribed, including controlled drugs. However, we looked at 15 MAR charts and found two gaps in the recording of medicines administered. We discussed this with the nurse in charge and the registered manager who were able to provide us with evidence that the two medicines had been administered and this was a recording error. The registered manager told us they would speak with the members of staff responsible and take appropriate action.

Running balances were kept for medicines that were not dispensed in the monitored dosage system. This meant that staff were aware when a medicine was due to run out and could make arrangements to order more. Where a variable dose of a medicine was prescribed, for example, one or two paracetamol tablets, we saw a record of the actual number of dose units administered to the person.

We observed that people were able to obtain their 'when required' (PRN) medicines at a time that was suitable for them. We saw PRN protocols in place which covered the reasons for giving the medicine, what to expect and what to do in the event the medicine does not have its intended benefit. This also included information such as risk assessments with certain medicines that had a sedating effect.

Staff said they received training in safeguarding adults and training records confirmed this. The service had a safeguarding policy and procedure and a whistleblowing policy in place and staff had access to these. A poster was displayed in the communal area explaining what abuse was and how to report this. There had been no safeguarding concerns since the last inspection.

Where there were risks to people's safety and wellbeing, these had been assessed. Person-specific risk assessments and plans were available and based on individual risks that had been identified either at the point of initial assessment or during a review. Risks identified included self-neglect, falls, social isolation and

nutrition. Each risk was analysed and included guidelines for staff to understand how to support the person effectively. For example, for a person at risk of falls, we saw, "Ensure [Person's] room is obstacle-free" and "Ensure [Person's] bed is on the lowest level, whilst they are in bed and that they have their call bell."

There were protocols in place to respond to any medical emergencies or significant changes in a person's wellbeing. Emergency contact numbers were accessible. Nursing and senior staff were available to help and support the staff and people using the service in case of an emergency.

Incidents and accidents were recorded and analysed by the registered manager and included an action plan to address any issues or trends identified. We saw evidence that incidents and accidents were responded to appropriately and care plans and risk assessments were updated accordingly. Lessons were learned and appropriate action was taken to prevent reoccurrence. For example, when a person had fallen from their bed and had sustained an injury, we saw that the provider had put a sensor mat and crash mattress in the person's room and had updated the person's risk assessment. We saw that there had been no further incident following this action.

The provider had a health and safety policy in place, and this was made accessible to staff and people living at the service. There were processes in place to ensure a safe environment was provided, including gas, water and fire safety checks. We saw evidence that all areas were regularly checked and any requirements were actioned appropriately. There were regular safety checks of equipment which included kitchen equipment such as extraction fans and moving and handling equipment such as hoists and slings and weighing scales. People were protected from the risk of infection and staff used appropriate protective equipment. All areas of the home were odour-free, clean and tidy and free of any hazards and all cleaning products were safely locked away.

The service had taken steps to protect people in the event of a fire, and we saw that a general fire risk assessment was in place. We saw evidence that checks of all fire safety equipment were carried out regularly. These included the fire alarm system and fire extinguishers. The service carried out regular fire drills and fire alarm tests and staff were aware of the fire procedure. People's records contained personal emergency evacuation plans (PEEPS). These included appropriate action to be taken in the event of a fire according to people's abilities and needs.

People and relatives told us they were happy with the staffing levels. The staffing records we viewed confirmed there were always sufficient staff on duty at any one time to provide care and support to people. One staff member told us, "Staffing is now more stable. We rarely need to use agency. Residents are more settled because we know them better." Recruitment practices ensured staff were suitable to support people. This included checks to ensure staff had relevant previous experience and qualifications. Checks were carried out before staff started working at the service. This included obtaining references from previous employers, reviewing a person's eligibility to work in the UK, checking a person's identity and ensuring a criminal record check was completed.

Good

Is the service effective?

Our findings

People's care and support had been assessed before they started using the service. Assessments we viewed were comprehensive and we saw evidence that where possible, people had been involved in discussions about their care and support. Assessments included background information which helped staff understand each person and their individual needs. Relatives thought that the staff team provided a service that met people's individual needs. A healthcare professional felt that the home managed people's needs well.

People were supported by staff who had appropriate skills and experience. All staff undertook training the provider considered mandatory such as health and safety, safeguarding, fire safety and infection control. They also undertook training specific to the needs of the people who used the service which included Mental Capacity Act 2005 (MCA), pressure care, dementia, bedrail safety and challenging behaviour. All staff employed at the service had achieved a recognised qualification in Health and Social Care, and had achieved or were undertaking the Care Certificate qualification. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. Training records confirmed that staff had completed the training identified by the provider to deliver care and support to the expected standard.

People were cared for by staff who were suitably supervised and appraised. The staff we spoke with told us that they received regular supervision and records we viewed confirmed this. They said that this had provided an opportunity for them to address any issues and to receive feedback on good practice and areas requiring improvement.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the provider understood the principles of the MCA and had followed its requirements. The manager had identified people for whom restrictions had to be put in place and had taken appropriate action to make sure that where the restrictions amounted to a deprivation of liberty these were in people's best interests. This included people who required the use of bedrails to prevent them falling out of bed, and the use of keypads to prevent people at risk going outside by themselves.

Care records we checked contained 'Do Not Attempt Resuscitation' (DNAR) forms. These are decisions that are made in relation to whether people who are very ill and unwell would benefit from being resuscitated if

they stopped breathing. These were authorised by the relevant healthcare professionals with evidence of consultation with the relatives where the person who used the service lacked capacity. This meant that people were being appropriately supported when decisions about their care were made.

All staff employed at the service had received training in MCA and DoLS. Staff we spoke with demonstrated a good understanding of the MCA and DoLS. They were able to provide examples of where they had assessed someone's capacity to make a decision and how decisions could be made in people's best interest if they lacked capacity. We saw information and posters in various areas of the home about the MCA.

The staff recognised the importance of food, nutrition and a healthy diet for people's wellbeing , and as an important aspect of their daily life. People's individual nutritional needs, likes and dislikes were assessed and recorded in an 'eating and drinking' care plan. There was a large pictorial menu displayed in the dining room and individual menus on each table.

The chef displayed a good knowledge of people's nutritional needs and preferences. Menu orders were received and pinned in the kitchen which included details such as puree requirements according to the person's name and room number. The kitchen staff gave us examples of particular people's requirements, for example, someone wished to have a jacket potato instead of what was on the menu and this request was accommodated. A healthcare professional told us that staff were particularly attentive on ensuring people stayed hydrated even when they were reluctant to drink.

People received the support they needed to stay healthy. Records showed that people's health needs were monitored and any concerns were recorded and followed up. There was evidence that people were referred to the relevant healthcare professionals when needed to ensure they received appropriate treatment. On the day of our inspection, the optician was visiting people using the service. Another healthcare professional told us, "I visit often and I do not have any concerns about the care provided." Care plans contained individual health action plans. These detailed people's health needs and included information about their medical conditions, mental health, medicines, dietary requirements and general information. This showed that the service was meeting people's health needs effectively.

The environment was designed to meet people's needs, in particular those living with the experience of dementia. For example, corridors and people's bedroom doors were brightly painted and there were photographs on bedroom doors if people had agreed to this. There were signs and pictures to help people find their way to their bedrooms, bathrooms or other communal areas. Notice boards displayed photographs of events that had taken place at the home. There were areas displaying tactile cues such as objects, dressing up items such as hats and scarves, dolls and pictures from the past for people to pick up and look at. The garden was well maintained and attractive and was being developed to include a sensory garden including edible herbs and scented flowers. There were tables, chairs and benches around and a 'bus stop'. These provided areas of interest, and enhanced the positive stimulation of people living with the experience of dementia.

The provider had made further improvements to the environment such as painting and decorating communal areas, installing new flooring and purchasing new furniture. The registered manager told us, "We are lucky. Whatever we need for the home, we get. It's all about making the place the best it can be for our residents."

Good

Is the service caring?

Our findings

People and relatives told us, and we saw people were treated with kindness, compassion and dignity. One person told us, "The staff are very friendly. They always knock on my door and ask if they can come in." Relatives' comments included, "The staff here are awesome", "The staff are very friendly and also very courteous to everyone, always offering me tea", "Care workers are very good and respectful" and "Staff are very caring. My [family member] is spoiled by them." A healthcare professional confirmed this and added that the staff team met people's needs with "consideration and compassion."

The staff and management team spoke respectfully about the people they cared for. Staff talked of valuing people and respecting their human rights and their diverse needs. It was clear from all the staff we spoke with that respect, dignity and personal choice were values they all shared and which they were proud of. There was a table in the entrance hall displaying a compliments book which contained thank you cards and letters from friends and relatives. Some comments we saw included, "Thank you for the gentle, kind and caring way you looked after my late [family member]" and "I just wanted to thank all of you for taking such good care of my [family member]." There was a "treasured memories" album which contained photographs of events celebrated at the home. This included the visit of the Mayor for a person who was celebrating their 100th birthday.

Staff displayed a gentle and patient approach throughout the day when caring for people in the home. We observed that staff communicated with people clearly and appropriately, making eye contact, offering choices and explaining what they were doing when assisting people. For example, we observed staff encouraging a person to do their exercises. Throughout the session, the staff member explained the benefit of particular exercises and said, "This will make your back stronger." We witnessed the person responding to this by fully participating. This was rewarded by praise and kind words. Staff were attentive when people needed assistance and responded promptly to their needs. They also encouraged people to remain as independent as they could be, for example when mobilising. We observed staff taking time and showing patience for a person who had expressed the wish to mobilise independently and their effort was met with praise and encouragement.

Staff demonstrated a good level of engagement with people. They were cheerful and good natured and took time to speak with people, interacting and chatting with them throughout the day. There was music playing throughout the morning, and we saw that people enjoyed singing along to songs. One person commented, "That's my favourite song", to which staff replied, "Is it? Who is singing?" The person said the singer's name and staff initiated a conversation about them.

People told us that staff respected their privacy and dignity. One person said, "They always ask permission to enter my room. People were well presented, in clean clothing and with clean hair and nails. There was a hairdressing salon and a hairdresser visited regularly to attend to people's hair.

People's religious and cultural needs were respected, and care plans included details of this. Church representatives and volunteers visited the home to help people pray and celebrate their religion. The

kitchen staff told us that different cultural diets were catered for. The home had a culturally diverse staff team and we saw that people whose first language was not English were able to engage in conversation with some staff. This helped ensure that people could communicate their needs and helped reduce social isolation.

Good

Is the service responsive?

Our findings

The provider employed two activity coordinators to help ensure that a range of activities were provided seven days a week. There was a record of activities for each person using the service. This included all activities undertaken each month. The activity coordinators had put in place a document named, "Getting to know me" for each person using the service. This included background information about people's hobbies and interests and which activities they enjoyed. Staff told us that this enabled them to support people with activities of their choice.

People and relatives we spoke with were happy with the activities organised at the home. One person told us, "The activity coordinator [Name] is very nice. I enjoy art, sometimes she comes here to help me with drawing." Relatives' comments included, "My [family member] is bed ridden. The activity coordinator brings a dog to visit [them]", "The queen's birthday party was celebrated and I saw all the residents enjoyed it and had fun" and "There were celebrations of Easter, Diwali, queen's birthday party and MacMillan coffee morning in the home." However one relative was less enthusiastic and told us there were "No activities in HDU (High Dependency Unit). We raised this with the activity coordinator who told us that the needs of the people in the unit were high and often they were unable to engage in activities. However they added that they engaged people in more sensory activities such as hand massage, music and gentle talk, and walks outside when the weather was good.

The provider had introduced virtual reality technology to the home. This software enabled people to travel to new places or back in time without leaving their armchairs. The provider told us, "The state-of-the-art system has the power to transport people with dementia into a number of stimulating alternative worlds while care workers engage them in conversations about what they are seeing, or even simply to transport back to the area or road they grew up on to see how it has changed. The technology would allow a virtual day trip to see cities such as Paris, Rome, Venice and other major cities and landmarks throughout the world." The registered manager told us that this technology had made a positive impact to people who had used it. For example, one person who had recently been admitted was reluctant to engage and tended to remain isolated. Gently, the activity co-ordinator and care staff introduced the person to the virtual reality. Once reassured that it was safe, the person became open to the idea. Staff were able to 'take' them to Google street view of a town in England where a close family member lived. Periodic use of virtual reality has encouraged the person to look forward to their sessions with the activity co-ordinator and they have become more willing to engage with others.

Staff told us they ensured there were opportunities to provide activities outside the home environment and within the community whenever possible. For example, they described taking a group of people to the local market and using the garden for events and celebrations. They also added that they celebrated religious events throughout the year.

A staff member described how they were able to identify preferences and use these within the care plan. For example, a person using the service was described as a very good dancer. By identifying their favourite music, they saw that the person became more active and more likely to join in dancing activities.

Staff were also responsive to relatives' needs. For example, when it was identified that a relative had difficulties visiting their family member, at a practical and emotional level, staff suggested sending a daily text message to them to inform them of their family member's progress. This had helped reassure the relative and was working well.

Staff told us they wanted to ensure that the home felt like a home and family environment. They described how, for some people, a hug gained a positive response. One staff member told us their favourite aspect of their job was to 'pamper' people, for example helping people choose hair and make-up styles and painting nails. We observed the same staff member later talking to a person using the service about hair styles after their shower. The person appeared to very much enjoy this interaction.

The registered manager showed us a room which was being developed into a reminiscence room. They told us that the room would have a double purpose, such as becoming a 'Night owl café' by night. This would provide an area of relaxation for people who were unable to sleep during the night, where they would be able to have a drink and chat to staff.

Care plans were comprehensive and contained detailed information about the care needs for each person and how to meet these. Each person's care plan was based on their needs, abilities, likes, dislikes and preferences. For example, what time people wanted to go to bed or have their meals. Care plans included a 'This is me' document. This detailed the person's background information, daily routine and how they wanted their care delivered. Relatives of people who did not have capacity told us they had been consulted about their family member's care plans and had agreed to these. They said they were well informed by the staff about the care their relatives received.

Staff took time to understand and meet people's individual needs. For example, one senior staff member explained that a person using the service had a strong attachment to a toy pet, and often asked the staff member to look after it whilst they took their medicines, or requested medical help for it. The staff member described how they validated the person's wishes and this helped build a trusting relationship.

The service had a complaints procedure in place and this was available to people who used the service and relatives. A record was kept of all the complaints received. Each record included the date, nature of the complaint, action taken and outcome. Where complaints had been received, we saw that they had been investigated and the complainants responded to in line with the complaints procedure.

People's end of life wishes were recorded in their care plan and they had advanced care plans in place. We saw evidence that people were supported to remain at the home until the end of their lives if they had expressed this wish. At the time of our inspection, one person was receiving end of life care. We saw that they were comfortable and well cared for and staff attended to their needs throughout the day. Staff on duty told us they followed advice from the palliative care team who was involved in the person's care. Staff received training on this area of their work.

Good

Is the service well-led?

Our findings

People and relatives we spoke with were complimentary about the staff and the manager. They said they were approachable and provided a culture of openness. Relatives' comments included, "The manager is good and we can approach them with any concerns we might have", "It seems they are doing their best", "I deal with management. [Family member] is safe here. I asked for the physiotherapist and nurse told me the referral had already been made" and "I am well informed about the health of my [family members]." A healthcare professional told us, "When the manager is there, the door to [their] office is open and [they] are very friendly and will have time to talk with me" and "I think the service is well led. I do not have any concerns at this time."

The registered manager was an experienced nurse who had worked at the service for six years. They had knowledge of the service, each person's needs and the areas of improvements needed. They kept themselves abreast of developments within the social care sector by attending conferences and seminars organised by the local authority, as well as reading publications and consulting relevant websites.

The provider made regular visits to the service and worked closely with the registered manager. They undertook monthly inspections of the service. These included checks of the building, the environment, issues regarding people who used the service and staff and documentation. The registered manager told us that they felt well supported by the provider and communication between them was good.

Staff we spoke with commented that there was an open and positive culture at the home. They felt that the clinical leads and the registered manager were visible and hands on. They all stated that they felt able to approach the registered manager with queries and ideas and felt listened to. Staff added that there was a shared responsibility across different staff groups and everyone 'mucked in'.

The registered manager had put in place a number of different types of audits to review the quality of the care provided. These included food hygiene standards, medicines audits, environmental checks, health and safety checks and care records. Audits also included people's weights, bed rails, tissue viability documentation and nutritional care plans. Audits were evaluated and where necessary, action plans were put in place to make improvements in the service. Records were kept of safeguarding concerns, accidents and incidents. We viewed a range of audits which indicated they were thorough and regular.

Staff told us they had regular meetings and records confirmed this. The items discussed included care plans, audits, environment updates, ideas for improvements and communication. Outcomes of complaints, accidents and incidents were discussed so that staff could improve their practice and implement any lessons learnt from the outcome of investigations. Staff meeting minutes confirmed this. There were also regular health and safety meetings, senior staff meetings, and meetings for people who used the service and their relatives. Some of the subjects discussed included complaints and concerns, improvements planned and ideas, mealtime and activities. This indicated that people, relatives and staff were involved in the development of the home and felt valued.

People and their relatives were encouraged and supported to feedback about the service through quality questionnaires. These questionnaires included questions relating to how they felt about the care and support they received and whether their needs were being met. We saw that the results indicated that they were happy with the service and the care provided.

The provider carried out yearly satisfaction surveys of staff and external professionals to gather their feedback about the service and identify any areas for improvement. The 2018 surveys had just been sent out at the time of our inspection. However we saw that last year's surveys showed an overall satisfaction with the service. Questionnaires were analysed by the registered manager and actions were taken where concerns were raised.

The provider produced a quarterly newsletter which was distributed to people and relatives to keep them informed about the service. These detailed information about events and activities undertaken, any improvements made to the environment, outcomes of inspections, staff news, fundraising activities and 'Thought of the month', for example, 'Kindness and a big smile goes a long way'.