Mrs Saima Raja

Victoria Lodge Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service responsive?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 13 and 14 January 2016. Breaches of regulations were identified during this inspection, and we are currently taking action against the provider in relation to this. We will report on this action at a later date. After that inspection we received information about concerns in relation to the service. As a result we undertook a focused inspection on 18 February 2016 to look into those concerns.

This report only covers our findings in relation to the concerns. You can read the previous comprehensive report from our last inspection, by selecting the 'all reports' link for Victoria lodge on our website at www.cqc.org.uk

We undertook this focused inspection to determine people who used the service were safe and received care that was responsive to their needs. We did not look at other areas during this inspection. Changes to the overall rating will not be given at this inspection, as we have only looked at two areas. This will be reviewed at the next comprehensive inspection.

Victoria Lodge Residential Home is a care home providing accommodation for older people who require personal care. It also accommodates people who have a diagnosis of dementia and can accommodate up to 24 people over two floors, the floors are accessed by a passenger lift. The service is situated in Edenthorpe near Doncaster.

The home had a registered manager. 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.

We found medication procedures had been improved, however we were not yet assured the Improvements had been embedded into practice and that the improvements made will be sustained. This was because at our last inspection in January 2016 we found the systems and processes to monitor the quality and safety of the service were not effective.

We found that people had care and support plans in place and these were reviewed and updated. However we identified these were not always person centred as many contained the same information. We saw risk assessments in place, but found the reviews were not always effective or accurate and staff did not always follow the care plans to ensure people's needs were met. We also found effective care plans were not in place for people who received a respite service. This put people at risk of receiving inappropriate care that did not meet their needs

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Although medicines management had improved, we still found that appropriate arrangements were not always in place to ensure people received medications as prescribed.

Risk assessments were in place but had not always been reviewed to ensure care and treatment was provided in a safe way.

At times there was not always enough staff deployed to provide people with individual support required to meet their needs.

Changes to the rating will not be given at this inspection. This will be reviewed at our next comprehensive inspection.

Is the service responsive?

Requires Improvement

The service was not always responsive

We saw people had health, care and support plans. The reviews were not always responsive to people's needs and they were not person centred.

Changes to the rating will not be given at this inspection. This will be reviewed at our next comprehensive inspection.

Victoria Lodge Residential Care 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 checked whether the provider is meeting specific requirements of the regulations associated with the Health and Social Care Act 2008. This inspection did not provide an overall rating under the Care Act 2014.

This inspection took place on 18 February 2016 and was unannounced. The inspection team consisted of one adult social care inspection manager, two adult social care inspectors and a pharmacy inspector.

Before our inspection we reviewed the information received from the local authority commissioners.

At the time of our inspection there were 20 people living in the home

We looked at other areas of the home including some people's bedrooms, communal bathrooms and lounge areas. We spent some time looking at documents and records that related to people's care, including care plans, risk assessments and daily records. We looked at seven people's support plans.

During our inspection we also spoke with seven members of staff, which included care workers, domestics, kitchen staff, the deputy manager, the registered manager and the provider was also present at the service during the inspection.

Inadequate

Is the service safe?

Our findings

On arrival to Victoria Lodge we asked the registered manager for the staff duty rota. This showed there was 3 care staff scheduled to be working at the time of our inspection. Within a short time of our arrival we saw there was a lot of staff in the communal areas of the home. We asked staff, the registered manager and the provider about this and were told that staff come in to the home on their days off and liked to interact with people who use the service.

However we still identified that the deployment of staff had not been reviewed following our comprehensive inspection in January 2016. At this visit we asked the registered manager what the dependency levels of people who used the service were. They said they had looked at levels with the provider and had determined the levels on nights and weekends were adequate. However, they were unable to explain what people's dependency levels were or how the staffing levels were determined. We looked at incidents and accident records. We identified in January 2016 there had been six accidents recorded in the accident file. All six had occurred when night staff were on duty and all recorded they were found on the floor in their bedrooms. There was also an accident recorded in February 2016 this also occurred at night and the person had walked into a door frame and was taken to hospital.

Since our visit we have been notified of two further incidents that occurred at night that had been referred to the local authority safeguarding team. We have requested the registered manager and provider reassess people's dependency levels taking account of the environmental layout and any risks to determine there are adequate staff are deployed at all times to ensure people are safe and their needs could be met. Staffing levels were not monitored to ensure these could meet the needs and ensure the safety of people who used the service.

We checked the safety of the premises and that appropriate systems were in place to ensure peoples safety. We found most checks had been completed and were maintained up to date. However we saw the electrical condition report on file dated 27 June 2014 summarised the condition as, "serviceable condition requiring some upgrading." It identified 21 urgent remedial works and five recommended improvements. It also said that following the works the system should be tested again by 27 June 2015. We found no records were on file to confirm the works had been completed. The provider said that the report and evidence of works completed may be at the other office; we have not received this following the inspection. We also found the portable appliance testing of electrical appliances was out of date. The last report on file was dated 8 January 2014 and identified the next inspection due on 8 January 2015. There was no evidence that that this had been done. We identified a plug on a bedside lamp in room 10 stated that it was next due to be tested in November 2013. Again the provider said this may be at head office but there was no evidence at the service this had been completed and we did not receive this information after our inspection. There was no effective system in place to monitor the quality and safety of services.

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our last inspection in January 2016, we judged the provider to be in breach of Regulation 12 of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider did not have appropriate arrangements in place to manage medicines. As part of this inspection we checked to see what improvements had been made.

The room used to store medicines was secure, with access restricted to authorised staff. Controlled drugs were stored in a controlled drugs cupboard; access to them was restricted and the keys held securely. There were appropriate arrangements in place for the management of controlled drugs, including record keeping. However, regular balance checks of controlled drugs had not been carried out recently.

Medicines which required cold storage were kept in a fridge within the medicines store room. Fridge temperatures had been recorded daily, but only the current temperature and not the maximum and minimum as recommended in national guidance. We found an antibiotic liquid in the medicines room which should have been stored in the refrigerator, but had been left out at room temperature. This was brought to the attention of the senior carer during our visit and the medicine was immediately placed in the fridge. Records showed the temperature of the room used to store medicines had been maintained within recommended limits.

We found a lack of information to guide staff how to safely administer when required medicines. The recording of whether one or two tablets were given when variable doses of pain killers had been prescribed was not always documented. Staff did not reconcile (check) peoples medicines with their GP on admission to the home, so they could not be certain people who used the service were receiving all of their medicines as the doctor intended. For example, we saw one person who had been in the home for five days, and staff had not yet established whether all of his regular medicines, including pain killers, were prescribed correctly. The date of opening had not been marked on all bottles of eye drops and oral liquids meaning we could not be sure they were fit for use.

This was a breach of Regulation 12(1), (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at nine medication administration records (MAR) during the visit and spoke with the senior carer who was administering medicines. Since the previous inspection, medicines had been given correctly, as prescribed. Medicines records were clearly completed to show that people had received these. Stock balances of medicines were checked and found to be correct.

The manager told us that a new system of stock management had been introduced since our last visit in an effort to reduce discrepancies in the balances of medicines. We were told all of the senior carers who administer medicines had recently attended a safe administration of medicines training course delivered by an external agency. We saw evidence of materials from the training to assess staff competency in administering medicines.

During the previous inspection, we found the audits used to monitor medicines management were not fit for purpose because they had failed to detect the shortcomings identified in our report. We saw evidence that audits were now being performed more frequently, and that clear action plans and outcomes had been documented following negative findings.

We looked at risks to people who used the service during our inspection. We reviewed five peoples care records, we found risk assessments were in place but had not always been reviewed effectively. For example one person's moving and handling risk assessment identified the person was prone to and at high risk of falls. During our observations in the lounge we saw they had a bandage on their leg which went under their

foot however they did not have any footwear on this foot when mobilising. This put them at risk of slipping on the floor when being assisted to stand. We spoke with a visiting health care professional who had also identified this and asked the staff to ensure the person was wearing appropriate footwear. We saw later the person was provided with footwear to use.

We also identified another person was at high risk of developing pressure sores. Their Waterlow assessment showed a score of 11 which meant they were at risk. On 17 February 2016 the District Nurse had noted during a routine assessment their buttocks were red with slow reperfusion of the area. The pressure ulcer daily assessment chart was recorded as checked and intact on Monday Tuesday and Wednesday of that week. The recordings had not identified the skin was becoming reddened and more at risk of a sore developing.

This was a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

During this inspection we carried out observations in the ground floor lounge areas. We saw music was playing and during that time two activities took place. We observed a game of skittles. There was little engagement with people who used the service to encourage them to be included in this game and it was quickly abandoned as people seemed disinterested or did not appear to understand what this activity was.

We observed a further game taking place by the activities coordinator to guess objects, animals or an activity beginning with a letter of the alphabet. The people who took part in this were encouraged and seemed to enjoy this game. We also observed a game of Jenga in the dining room. Three people took part and were very enthusiastic. One person said, "That was good, let's have another game."

The registered manager informed us the activity coordinator had changed again since our visit in January. The laundry assistant had changed roles and was at the time of our visit assisting with activities.

During our observations we saw staff interaction mostly to be kindly and staff displaying patience with people who used the service. We did however observe one person who used the service kept getting up and asking to see her sister or to go out. We observed a staff member to keep asking them to sit down, although this was not done unkindly there was very little to reassure this person or distract them with something else.

We looked in detail at five care plans. We found that people had care and support plans in place and these were reviewed and updated. However we identified these were not always person centred as many contained the same information. For example every care plan we looked at detailed the person required a bath twice a week. We found from looking at the bathing records which showed that people did not always receive a bath twice a week, it was usually less and some weeks people did not have a bath. We looked at the daily notes and cross referenced this with the bathing record for two people. We saw that although the bath record indicated they had received a bath once per week in February, the daily notes for those days did not reflect the person had received a bath on those days.

Although care plans had been reviewed we found these were not effective as people's changing needs had not been identified. For example one person's moving and handling care plan did not reflect the person's current level of need. The care plan indicated the person required one person to assist them however this did not reflect the current care they required. We observed this person required two members of staff to support them to stand and walk. We also saw they used a wheelchair to mobilise. The person also had a Waterlow assessment of 11 and included that they were doubly incontinent. Their care plan did not identify any continence issues and at the last review on 29 January 2016, stated there was no change. We also found one person had a bandage on their leg and the care plan had not been reviewed to ensure they were receiving the hygiene needs they currently required. The reviews of peoples care needs were not responsive to their changing needs.

We saw in one care file that the person had suffered a bang to their head and left leg on 6 February 2016. The daily records showed staff had monitored the person during the shift and a body map had been added to their notes indicating where the injuries had occurred. Although the person appeared to have not suffered an impact on their health or wellbeing as a result of this, we saw there was advice sought, no accident form or incident completed and there was no further monitoring or evaluation of their injuries in the daily records. The Registered Manager was not aware of this and agreed to look into the matter.

We also identified some care plans contained contradictory evidence, which could cause confusion on how to meet people's needs. For example one person's mobilising care need stated they required one member of staff to observe them when mobilising, however, the Waterlow chart stated they were fully mobile. Another care plan identified a person at high risk of not receiving adequate nutrition and weight loss. The care plan identified they needed to be weighed weekly. The last three dates recorded when they were weighed were 21 December 2015, 4 January 2016 and 18 January 2016 this was not ensuring the care plan was followed. We also found a moving and handling care plan for another person which stated they required one staff member to assist them to mobilise, the review stated their mobility was currently good yet the moving and handling risk assessment showed the person was non mobile and required a wheelchair. These meant reviews were meaningless if staff were not recording accurate information or were not following the changes implemented at review to ensure people needs were met. This put people at risk of not receiving safe care and treatment.

We identified some of the reviews were also not recorded correctly and gave incorrect scores when a care need changed. We saw individual scores had changed due to changes in needs but the total remained the same which was incorrect as the total had actually changed. This did not ensure people's needs were appropriately reviewed to ensure their needs were met.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.