

# Victoria Care Elite Limited

# Victoria Grand

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

**Requires Improvement** ●

Is the service responsive?

**Requires Improvement** ●

Is the service well-led?

**Requires Improvement** ●

# Summary of findings

## Overall summary

### About the service

Victoria Grand is a residential care home providing accommodation and personal care for up to 26 people. The service provides support to older people, people with dementia and younger adults. At the time of our inspection there were 13 people using the service. The care home accommodates people in an adapted building over 3 floors, there is a lift to connect the floors.

### People's experience of using this service and what we found

There were not always enough suitable staff to provide safe and effective care to meet people's needs, including at night-time and for social support.

Risks to people were not always identified, assessed or managed effectively. Some people needed support with mental health needs and expressing feelings of distress or agitation. Staff did not have clear guidance about the level of risk and strategies to provide care safely. Medicines were not always managed safely because some protocols lacked detail to ensure staff had the information they needed when they administered medicines. Environmental risks and infection prevention and control risks were not always identified and managed. This meant there were increased risks of avoidable harm to people.

People were spending the majority of their time in their rooms, and some reported feeling isolated, bored and lonely. A person said, "I can spend hours and hours on my own." Another person told us, "I am in my room a lot of the time, in fact most of the time." Organised activities happened for a few hours on 2 afternoons a week. People said they saw no point in leaving their rooms because there was nothing to do. Staff told us they were too busy to spend time with people.

Care was task focused and care plans did not always support a personalised and holistic approach. Some people had mental health needs, but records did not reflect the support they needed. Staff told us they knew people well and this mitigated risks to some extent, but the lack of personalised records meant the provider could not be assured that people were receiving the care they needed and new or unfamiliar staff did not have all the information and guidance to support people.

Systems for assessing the quality and safety of the service were not all effective and robust. Audits had been undertaken on a regular basis but did not always identify shortfalls to drive improvements. A lack of effective leadership and management systems, including contingency plans, were not robust and this meant safe staffing levels were not maintained.

Staff understood their responsibilities for safeguarding people. People told us they felt safe living at the home, and they described kind and caring staff. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

#### Rating at last inspection

The last rating for this service was good (published 31 October 2018).

#### Why we inspected

The inspection was prompted in part due to concerns received about staffing and the management of the home. As a result, we undertook a focused inspection to review the key questions of safe, responsive and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe, responsive and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report. Following this inspection, the provider confirmed that they had taken action to make improvements.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Victoria Grand on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

#### Enforcement

We have identified breaches in relation to staffing, risk management, person-centred care which includes meeting people's social needs, and leadership and management at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

#### Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

## 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 was not always safe.

Details are in our safe findings below.

**Requires Improvement** ●

### **Is the service responsive?**

The service was not always responsive.

Details are in our responsive findings below

**Requires Improvement** ●

### **Is the service well-led?**

The service was not always well-led.

Details are in our well-led findings below.

**Requires Improvement** ●

# Victoria Grand

## Detailed findings

### Background to this inspection

#### The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

#### Inspection team

This inspection was undertaken by 2 inspectors.

#### Service and service type

Victoria Grand is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Victoria Grand is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

#### Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A manager had been in post since November 2022 but had not yet submitted an application to register. They were not at the home during the inspection.

#### Notice of inspection

This inspection was unannounced.

#### What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

#### During the inspection

We spoke with 7 people and a relative about their experience of the service. We spent time observing staff providing care to people and spoke with 6 staff, including 4 care staff, the chef, the maintenance person and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records relating to people's care and the governance of the service.

Following the inspection we received information from the provider about incidents and accidents, a care plan and updated medicine records.

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment; Using medicines safely

- There were not always enough suitable staff to care for people and medicines were not always managed safely. People and relatives confirmed that needs were not always met in a timely way. A person said, "They [staff] don't always come at once. Sometimes it's an eternal wait and that frustrates me a lot. Sometimes I have waited half an hour."
- Staffing levels were inconsistent and did not match the provider's calculated staffing level requirement. Staff told us there were not always enough staff to cover all the shifts including at night. We sampled rotas and confirmed that staffing levels did not match the calculated staffing levels. For example, a person, who was at very high risk of developing pressure wounds, required 2 staff to support them with their care. Records showed that there was not always 2 members of staff on duty to support them safely. This meant the person was put at risk of injury because there were not enough suitable staff to support them.
- Failure to ensure there were enough suitable staff on duty at night meant measures to support people in the event of an emergency, such as a fire, were not in line with the provider's fire risk assessment. This meant people were put at risk of harm.
- Medicines were not always managed safely. Some people were prescribed as and when required (PRN) medicines. Some medicines required additional checks from 2 trained staff to ensure medicines were administered safely. There were not always enough suitable staff on duty to provide these additional checks. This meant people were at risk of accidental harm from incorrect administration or medication error.

The failure to ensure there were sufficient, suitable staff deployed to meet people's needs was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, we asked the provider for assurances that systems had been reviewed to ensure safe staffing levels were being maintained. They confirmed that they had recruited additional staff and had adequate systems in place to ensure people were safe.

- Protocols to guide staff in how and when to administer PRN medicines to people were not completed consistently and some lacked clarity. For example, a person had been prescribed medicine to support them when they were anxious or distressed. The PRN protocol did not provide clear guidance for staff in how to recognise signs, symptoms or behaviour that would indicate when they should administer the medicine. There was a risk the medicine could be inappropriately administered. Following the inspection, the nominated individual confirmed that suitable protocols were now in place for all PRN medicines.
- People told us they were receiving their medicines when they needed them, and we observed staff were

knowledgeable about people's needs and the medicines they were prescribed. Medication administration records (MARs) charts were completed accurately.

- Staff recruitment was safe and all necessary pre-employment checks had been completed.

Assessing risk, safety monitoring and management; Preventing and controlling infection, Learning lessons when things go wrong

- Risks to people were not consistently assessed, monitored and managed safely. Environmental risks were not consistently managed. This put people at an increased risk of avoidable harm.
- For people who needed support with their mental health needs or how they expressed feelings of distress and agitation, there was not always an assessment to identify the level of risk to themselves or others. For example, the risks for a person with enduring mental health needs had not been assessed and there was not a care plan to support these needs. There was a lack of clear guidance or strategies for staff in how to support a person when they were distressed. Staff said they were told to keep out of the way and step back to stay safe.
- Incidents were not consistently recorded and analysed to identify possible causes and review strategies for supporting people. Recent incidents had not been recorded and this meant risks were not always managed and there were increased risks of avoidable harm to people and staff.
- Some areas of the home were in poor repair. A conservatory on the ground floor had 6 buckets to catch water from the leaking roof. These created a trip hazard and there was no risk assessment to ensure measures were in place to reduce this risk.
- We were not assured that the provider was supporting people living at the service to minimise the spread of infection. An area of the home smelt strongly of urine due to failures in supporting a person with their continence needs. Staff and the nominated individual were aware of this issue but had failed to ensure the person's room was adequately cleaned in line with the provider's infection prevention and control policy.

The failure to identify, assess and manage risks effectively, including infection prevention and control risks, was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There was a system in place to record and monitor incidents and accidents, which included lessons learned. Previous records showed how staff recorded incidents and the actions that had been taken. For example, a person had fallen and suffered a minor head injury. Staff had increased monitoring to check on the person's welfare following the fall in line with the provider's procedures following a head injury.
- Records included examples of lessons learned, for example following a flood staff were provided with information about the location of stop cocks in the building to prevent a similar incident.

Systems and processes to safeguard people from the risk of abuse

- Staff had received training on safeguarding and demonstrated an understanding of their responsibilities. A staff member told us, "I would always report any concerns to the manager or [nominated individual]."
- People told us they felt safe living at Victoria Grand. A person said, "Yes I definitely feel safe here, I wouldn't want to be anywhere else."

The Mental Capacity Act 2005 (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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is



usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were socially isolated and had limited opportunities to take part in activities that were meaningful and relevant for them. A person said, "Lately I haven't been able to go out." They explained this was because they needed support from staff to go out and there were not enough staff on duty to accommodate this.
- People did not always have access to meaningful activities or social interaction. We observed that most people were spending the majority of their time in their bedrooms with little social engagement. For example, at 11am, after having support with personal care, only one person came downstairs during the morning. A person told us they rarely left their room. They explained they used to come downstairs but now there was no reason to leave their room because, "We were doing activities and now we are not allowed to do it." Staff told us people had stopped leaving their room during the pandemic and this seemed to have continued although there was no reason for them to have to remain in their rooms.
- People we spoke with said they were lonely and often felt bored. People said they did not have enough to occupy them and saw little point in leaving their rooms even at mealtimes. A person commented, "I keep feeling homesickness, boredom and loneliness. I am in my room a lot of the time, in fact most of the time unless I get someone to take me downstairs in the wheelchair."
- The provider had employed a person to support activities on 2 afternoons during the week. People said they enjoyed these activities but there were limited opportunities for social interactions. A person said, "We go downstairs from 1pm until 3pm for activities, today would be the first day for a while. The last time was about a week ago."

The failure to support people's need for meaningful occupation, sustaining contact with the community and social engagement was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- People were not always enabled to have as much choice and control in their lives as they should expect, because staffing levels did not support this. This had a negative impact on people's quality of life.
- Care was planned and provided in a task focused way and did not consider people's whole life needs. For example, we noted that daily records focused on what care was provided, what people had eaten and their medicine. There was a lack of consideration for their mental health needs, occupation or stimulation during the day. A staff member told us the lack of staffing had an impact on people's quality of life, saying, "You can't give the residents time because you are doing the work of three people."
- Care records were personalised in some areas but not consistently. For example, some people had

psychological needs that had not been considered. This meant staff did not have all the information they needed to provide responsive support for people.

- People's wishes for care at the end of life had not been fully considered. Where people had specific wishes or plans these were noted but records lacked personalised detail that would guide staff in how a person preferred care to be delivered in their last days.

The failure to provide a personalised service that was responsive to people's needs and preferences was a further breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

#### Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- The provider had not ensured the Accessible Information Standard was implemented. For example, a person had sensory loss and told us they spent all their time in their bedroom due to mobility issues and failing eyesight. They were not able to watch television anymore and said they did not have the radio on because it would require staff to turn it on and off and they (staff) were too busy to help with this. We noted the communication care plan failed to identify their visual sensory loss. It identified that the person was able to communicate their needs verbally but did not provide further information about their sensory needs and how to support them.

The failure to support people with their communication or sensory needs was a further breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

#### Improving care quality in response to complaints or concerns

- The provider had a system for recording complaints and concerns. Records showed that complaints had been considered and written responses had been sent.
- The nominated individual gave an example of how improvements had been made following a complaint. They described how a visitor had not been able to gain entry to visit a person because the doorbell was not working. They had received an apology and a new doorbell system had been implemented.

# Is the service well-led?

## Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- Management arrangements had failed to provide consistent leadership that supported good outcomes for people, and quality and assurance systems in place were not effective. Systems for monitoring quality and improving care had not identified shortfalls. For example, risks associated with people's emotional well-being were not consistently assessed and managed.
- Systems for monitoring the quality of the service were not consistently effective. Management systems had not ensured there were always adequate staffing levels, that staff were responding to call bells in a timely way or identified risks relating to infection prevention and control. For example, due to the lack of senior staff, gaps in the staff rota had not been identified and filled. These shortfalls meant people were at risk of harm. The nominated individual explained they had been unable to find suitable staff at short notice to provide adequate cover. This brought into question the effectiveness of the provider's contingency plans for staffing.
- There had been a failure to report the lack of staff on duty to CQC or the local authority. This demonstrated a lack of understanding about the provider's responsibility to be open and honest when something goes wrong.
- The provider had recruited a manager in November 2022, but they had not yet registered with CQC. During the inspection the manager was not at work and the nominated individual could not confirm a timescale for their application to become a registered manager. They gave assurances that they would keep CQC informed about the managerial arrangements at the home. Staff told us how the lack of senior staff meant they were sometimes without a manager at the home. A staff member told us, "My responsibilities are growing rapidly. I am having to do things a deputy would do."
- There was not clear leadership at the home. For example, staff did not receive guidance or clear direction from a shift leader. There were no systems in place to identify which tasks staff were to undertake. A staff member said, "It's difficult when we don't have a manager in the building to guide us in the right way." The nominated individual said that staff had all worked at the home for a long time and were able to make arrangements between themselves. The lack of leadership meant there was a risk that any new or inexperienced staff might not receive the information, guidance, leadership and support they needed, and that key tasks or risks might not be identified and managed.

The lack of effective management systems to assess and manage risks and improve the quality of the service meant there was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others;

- People told us they did not feel engaged and involved in a meaningful way. A person said, "We don't have meetings and I haven't been asked for my views." A relative told us they had communication from the manager, but this was not a regular occurrence.
- Staff did not always feel engaged, or their concerns were listened to. A staff member told us, "The thing that worries me most is the staffing and the complete denial there is a problem."

This section is primarily information for the provider

## Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care  There was a failure to support people's need for meaningful occupation, sustaining contact with the community and social engagement. There was a failure to provide a personalised service that was responsive to people's needs and preferences.

### The enforcement action we took:

We issued a warning notice requiring the provider to become compliant with the regulation within a given timeframe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment  There was a failure to identify, assess and manage risks effectively, including infection prevention and control risks.

### The enforcement action we took:

We issued a warning notice requiring the provider to become compliant within a specific time frame.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  There was a lack of effective management systems to assess and manage risks and improve the quality of the service.

### The enforcement action we took:

We issued a warning notice requiring the provider to become compliant within a given timeframe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing  There was a failure to ensure there were sufficient, suitable staff deployed to meet people's needs.

### The enforcement action we took:

We issued a warning notice requiring the provider to become compliant within a specific timeframe.