HC-One Limited

Victoria Park (Coventry)

Inspection report

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29 August 2017
19 October 2017

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

During our previous inspection visits to Victoria Park in July 2016 and May 2017, we identified medicines were not consistently managed safely. We could not be sure medicines were disposed of safely. We found the provider to be in breach of the regulation in regards to 'safe care and treatment'. Issues of concern related to medicine management were not being identified and addressed in a timely way. We served a warning notice to the provider. We asked them to make the necessary improvements as stipulated in the warning notice within a short timescale.

During our inspection visit on 29 August 2017 and 19 October 2017, we checked people at the home received safe care and received their medicines as prescribed. We found people received their medicines safely when they needed them and sufficient action had been taken to meet the requirements of the warning notice. However, we found improvements were needed in regards to other aspects related to people receiving safe care.

Risks associated with people's care were identified but we found risks were not always effectively managed. Staffing arrangements meant some people did not receive care and support in a timely manner.

Accidents and incidents were recorded and acted upon by the registered manager. Equipment that people used was checked to make sure it was safe although records were not always in place to confirm this.

Staff were subject to recruitment checks to make sure they were safe to work with people at the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People received their medicines as prescribed. Staff understood the risks related to people's care but checks were not always completed to ensure risks were consistently managed. Staffing arrangements were not always effective to keep people safe. Monitoring checks were carried out to ensure equipment people used was safe and further safety checks were being implemented. Recruitment procedures reduced the risks of employing unsuitable staff.

Victoria Park (Coventry)

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.

The inspection was carried out on 29 August 2017 and 19 October 2017. The visit on 29 August 2017 was carried out by a medicines inspector (pharmacist). This was to check medicines were managed safely and to check compliance with the warning notice. The visit on 19 October was carried out by one inspector to check people received safe care and support. Both visits were unannounced. We reviewed the 'safe' domain only to check that improvements had been made and to check people in the home received safe care.

During the inspection we spoke with seven people and one relative to gather their views about people's safety and care. We spoke with seven care staff plus the maintenance person, the registered manager and area director. We looked at six care plans to review risks associated with people's care. We also looked at a range of records including, accident and incidents, medicine records, recruitment records and records staff completed each day to monitor people's safety, care and welfare.

We also looked at the information received from statutory notifications the provider had sent to us. A statutory notification is information about important events which the provider is required to send to us by law.

Requires Improvement

Is the service safe?

Our findings

At the time of our last inspection on 17 and 22 May 2017 we found the provider was in breach of regulation associated with the management of people's medicines. We served a warning notice and the provider sent us an action plan outlining how they would improve. At this inspection people told us they received their medicines when required. One person told us, "I am very happy with how my medicines are being administered." Another person told us, "I am getting my inhaler and tablets okay."

We looked at the Medication Administration Records (MARs) for people, including those records used to record the application of topical preparations such as creams. We found they had been correctly completed and demonstrated people were receiving their medicines as prescribed. Where medicines were prescribed to be administered 'when required', there was detailed information available for the staff to be able to administer these medicines safely and when people required them.

We looked at the records of two people who were administering some of their medicines independently. Risk assessments had been completed for both people to demonstrate they could manage their own medicines safely. Staff were aware of what medicines were being independently administered and we were assured these medicines were being managed as prescribed.

We looked at records for people who had pain relief patches prescribed to be applied to their body. At our previous inspection records did not clearly show how these patches should be applied and it was not clear how they were being managed. We found the provider had taken action to address this and there were clear records of how the patches were being used. The patches were being applied in accordance with the manufacturer's guidelines. The provider was able to demonstrate sufficient improvement had been made as patches were being applied safely and people's pain controlled.

The provider had noted that one of the refrigerators used to store medicines was not working properly and had taken this out of service. They told us they were waiting for the pharmacy supplier to replace it. The provider was therefore using one refrigerator to store all of the medicines that required cold storage conditions. We found staff were measuring and recording the refrigerator temperatures correctly. However, temperature records showed that from the 12 to the 28 August 2017 the maximum temperature was 11°C, when the maximum should not exceed 8°C. This had not been identified as part of the audit checks of medicines because these were done on a monthly basis by the senior care staff. The medicines stored in the refrigerator could tolerate being stored for up to a month at room temperature. This meant the raised refrigerator temperatures over this short term would not have impacted on the effectiveness of these medicines. The registered manager told us she had increased the number of checks made to ensure medicine management was consistently safe.

People told us they felt safe living at Victoria Park. However, they had mixed views about enough staff being available to support them, because of how they experienced their daily care. One person told us they felt "guilty" when they needed to ask a staff member for support because they could see staff were busy. We saw when people used call bells, they were not always responded to in a timely way. One person had been

waiting around 25 minutes to be assisted to the toilet.

During the morning there were two staff members working on one floor. One staff member was administering medicines which meant there was one staff member to support others for most of the morning. A number of these people needed two staff to support them when moving. The care staff member who was administering medicines was interrupted on several occasions by people who needed assistance. We were concerned this could place the care staff member at risk of making medicine errors.

We saw there were periods of time during the day when people received delayed support. One person had waited for two hours for their wet clothing to be changed after spilling their drink. At the time they asked to be assisted, one of the two care staff available was busy administering medicines. A staff member from another floor was requested to assist. When they arrived the person was escorted to the table for lunch and after lunch was taken to the hairdresser and not to their room to change. There was a lack of communication between staff to ensure this person was assisted in a timely manner, this was despite us having alerted several staff, the person needed to change their clothes. We told the registered manager and the provider's area director of this and the area director immediately checked the person's clothing was changed.

Staff told us an extra member of care staff was needed each day so there were two senior care staff and four care staff on duty to support the two floors. One staff member told us, "I am running between everything, there is only two of us, we need another carer." Another told us, "It's very safe yes, when we have enough staff." One staff member said they struggled when only two care staff were on the shift when medicines were being administered. They told us, "It's watching the carer struggle to get people up in the morning. When people are asking for the toilet and you are doing the medicines it's hard."

We discussed concerns in relation to staffing arrangements with the registered manager. They told us a staff member was on annual leave but later arranged for an additional staff member to be made available to support people. The area director told us staffing arrangements had been reviewed to enable there to be three care staff on each floor.

We saw care staff from a staff agency worked in the home when shifts could not be covered by regular staff. Staff said the number of agency staff used varied each week with sometimes there being none and other weeks where several shifts were covered by them. Staff told us when agency staff worked in the home, sometimes it placed extra pressures on them particularly if the agency staff member had not worked at the home before. The registered manager and area director told us they were asking regular staff to cover shifts more to reduce agency staff usage.

Staff understood the different types of abuse and the signs of potential abuse so action could be taken to keep people safe. They knew to report any concerns to their manager. Procedures were in place to protect people from harm such as the provider's safeguarding procedure and whistleblowing procedure. (A whistle blower is a person who raises concerns about wrong doing in their workplace). However, a staff member spoken with did not know where the whistleblowing procedure was kept to refer to this if needed.

People's needs had been assessed so that any risks associated with their care could be managed. Staff knew about risks and their responsibility to manage them and keep people safe. We saw when staff moved people from wheelchairs to comfortable lounge chairs, they followed safe moving and handling techniques. This included giving clear instructions to the people they were moving. We saw staff used aprons and gloves to help maintain good infection control in the home although a visitor said they had seen some poor infection control practice. We discussed infection control procedures with the registered manager to ensure

actions were taken to protect people from infection risks.

Staff were required to complete a number of daily checks on people to make sure they were safe. Overall, we saw checks were completed as required. For example, one person was at risk of choking when eating so they were checked hourly when they were in their room. Staff told us any meat was cut into small pieces because the person, who had capacity to make their own decisions, chose not to have this pureed. A staff member told us the person fully understood the risks of eating food that was not pureed and ate mostly in the dining area where they could be observed.

There were some risks that were not consistently managed such as those related to the risk of falling. One person at risk of falling told us they could not hear or see us. When we asked a staff member about this person they told us they should be wearing their glasses. When we looked at the person's records we saw there was a 'falls risk assessment' but this did not contain an instruction for staff to check the person was wearing their glasses. Failure to ensure the person could see clearly when they were walking increased the risk of them falling. The staff member collected the glasses for the person after we spoke with them.

Prior to our inspection we were told about a person who had fallen out of bed onto a crash mat. This had not been identified by staff in a timely way because the alarm mat beside the bed had not worked to alert staff. As a result of this, staff told us they had been asked to undertake regular checks of the mat to help manage this risk. The provider had implemented a form for staff to record checks undertaken. However, this form had not been implemented in a timely way as it had only been put in place on the day of our inspection (19 October 2017). The incident had occurred in June 2017. There were instructions for staff to check the mat four times a day.

Mattress checks were carried out by the maintenance person on a monthly basis to make sure they were safe to use and not damaged. Care staff said they were not recording any daily checks of mattresses such as airflow mattresses, to make sure they continued to be inflated. This was important to minimise and prevent the risk of people developing skin damage should the mattress deflate. The area director advised the registered manager to implement these checks during our visit.

Action had been taken to ensure people at risk of poor nutrition and hydration were eating and drinking enough. We saw the amount of food and drinks people consumed were recorded on food and fluid charts each day, so this could be monitored to help ensure people were not placed at risk. Charts showed snacks and high calorie drinks were provided in addition to meals to increase people's calorie intake where needed. We found sometimes when people's fluid intake was low, action in response to this was not always detailed on the charts to ensure this risk was sufficiently addressed. Daily records did not always give a possible reason for the low fluid intake and sometimes conflicted with information on the charts. The registered manager and area director told us records were being reviewed to ensure food and fluid monitoring was effective and any issues of concern addressed.

Accidents and incidents were recorded and records showed they were reviewed each month by the registered manager so they could identify any actions required to reduce the risk of them happening again. Action had been taken to ensure these were reported to us as required.

The provider's recruitment procedures included the necessary checks to ensure new staff were of good character and suitable to work with people. Records confirmed checks included written references and a Disclosure and Barring Service (DBS) check before they started work. The DBS assists employers by checking people's backgrounds for any criminal convictions to prevent unsuitable people from working with people who use services.