Serving All Limited

Vauxhall Court Care Home

Inspection report

Vauxhall Court Residential Care Home
Vauxhall House, Freiston Road
Boston
Lincolnshire
PE21 0JW

Tel: 01205354911

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08 February 2017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 8 February 2017 and was unannounced.

The home is registered to provide accommodation and personal care for up to 33 older people some of who may be living with a dementia. There were 28 people living at the home on the day we visited.

There was a registered manager for the home. 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.

At our last inspection in February 2016 the provider was not meeting the legal requirements in relation to medicines. At this inspection we saw that the provider had taken action to ensure people were consistently offered their medicines and was meeting the regulations. However, more improvement was needed around the recording of medicines prescribed as required (known as PRN). At this inspection the provider was not meeting the legal requirements in relation to providing person centred care. They had not ensured that care was planed to reflect people's needs or that people were involved in planning their care. You can see what action we told the provider to take at the back of the full version of the report.

The rating for our inspection in February 2016 was requires improvement and this has not changed at this inspection. Therefore, the registered manager and provider had failed to make the changes needed to provide a good level of care for people. This was because while the care was safe it did not reflect the standards of good practice that we expect to see in the environment for people living with dementia or the care plans in place to support people. The systems in place to monitor the quality of care had not identified these concerns.

People had all their basic needs met and received safe care which met their needs. Staff were trained to recognise situations in which people may be at risk of abuse and to take the appropriate action. However, the registered manager had not always reported this type of incident in an appropriate way.

People received appropriate food and drink to stay healthy and had access to healthcare professionals when needed. However, some people living with a dementia liked to spend time walking around the home and this impacted on others living at the home. There were no care plans or activities in place to manage this behaviour.

We have recommended that the provider review the guidelines for providing care for people with long term conditions and for those living with dementia.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to

protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect
themselves. We found the registered manager had taken appropriate action to comply with the requirements of the MCA and therefore people's rights were protected.

The staff at the home were kind, caring and considerate of people's needs and constantly monitored them to ensure they were safe and their needs were being met. There were enough staff to meet people's needs and they received appropriate training and support to develop the skills needed to provide safe care.

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.

Medicines were safely administered. However, systems did not support the consistent administration of medicines prescribed as required.

Staff had received training in abuse and knew how to raise concerns. However, the registered manager had not raised some incidents with local safeguarding team.

Most risks to people while receiving care had been identified. However, risks posed by people who liked to walk around the home were not managed.

There were enough staff to meet people's needs safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider had not ensured that the environment supported people with dementia to be engaged and independent.

Staff received appropriate training and support to develop the skills needed to provide safe care.

People were supported to maintain a healthy weight.

People were able to access healthcare professionals when required.

Is the service caring?

Good

The service was caring.

Staff were kind and caring and ensured that people's needs were recognised and met.

Staff supported people to make choices about their care and to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People received person centred care which met their needs. However, care plans did not reflect the level of care people received or needed.

Activities were not used to support people living with dementia to be happy and calm.

People knew how to complain and the registered manager ensured complaints were thoroughly investigated.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The registered manager had a suite of audits to monitor the quality of care provided, but these had not identified the issues we found during the inspection.

The provider and registered manager had not made enough improvements to change the rating from requires improvement and had not ensured that care kept up to date with the guidance on best practice.

People had their views about the service gathered and analysed and action was taken to improve the quality of care they received.

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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 inspection took place on 8 February 2017 and was unannounced. The inspection team consisted of an inspector, a specialist advisor, who was a social worker 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.

Before the inspection we reviewed the information we held about the home. This included any incidents the provider was required to tell us about by law and concerns that had been raised with us by the public or health professionals who visited the service. We also reviewed information sent to us by the local authority who commission care for some people living at the home. Before the inspection, the provider completed a Provider Information Return (PIR). 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 the inspection we spoke with two people who lived at the service and four family members who visited the home. We spent some time observing care. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the provider, the registered manager and the deputy manager; we also spoke with a team leader, a senior care worker, a care worker and the activities coordinator. There was an external trainer at the home and we gathered their views on the home and training programme.

We looked at 11 care plans and other records which recorded the care people received. In addition we examined records relating to how the service was run including staffing, training and quality assurance.

Requires Improvement

Is the service safe?

Our findings

When we inspected in February 2016 we found the provider was not meeting the legal requirements in ensuring people had access to their medicine. Following the inspection the provider wrote to us and told us the actions they would take to resolve these issues.

When we inspected in February 2017 we found the provider had made all the improvements needed and was meeting the legal requirements. People told us that their medicines were always available to them. One person said, "I usually rely on them to bring them. They bring them some at night and there's some I take at breakfast and that all seems to work okay." Another person assured us that their medicine was available at any time they needed it. There were systems in place to ensure that medicines were reordered in a timely fashion.

Most of the medicine administration records (MAR) contained the information needed to administer medicines safely. They included a picture of the person, their allergies and their preferred method of taking their medicine. For example, one person preferred to take their medicines one at a time on a spoon with a glass of juice.
However, some of the MAR were missing the identification photograph.

Some people had their medicines administered in a skin patch which needed changing after a number of days. There were clear records showing when and where each patch had been applied and when they had been removed. Where people had their medicines prescribed to be taken as required, known as PRN, there were some protocols in place to support staff to administer them consistently, however, this was not always the case. In addition there was inconsistent recording of why PRN medicines had been administered. This meant it was not possible to review the person's needs accurately to see if they needed any changes to their medicines. Some medicines had been crushed to make them easier for the person to swallow, however, advice had not been sought from a pharmacist to ensure this was appropriate for the medicine.

We recommend that the provider and the registered manager review the good practice guidelines for medicines prescribed to be taken as required.

Medicines were safely stored and administered. Staff told us that they had completed appropriate training around administering medicines safely. In addition, they had their competence checked by the deputy manager. A member of staff explained how the medicines round was split between two senior members of staff, to ensure that people were offered their medicines in a timely fashion. Where people were asleep when the medicine round was completed staff told us they would check the person at intervals and offer them their medicine when they awoke. Additionally if people refused their medicines staff would continue to offer them through the day.

Some people received their medicines covertly. This was because they may not have capacity to understand why they needed to take them or the effect on their health if they did not take them. Where people had received covert medicines records showed that this decision had been made in their best interest. In

addition, we could see that other options were discussed all with healthcare professionals that may make it easier for the person to take their medicine before covert medicines were used. For example, one person who was spitting out their tablets was given liquid medication and was taking this appropriately.

Staff had received training in safeguarding people from abuse and were clear on the actions they needed to take to protect people from abuse. Staff told us that if they raised any concerns the management team were responsive and took action to keep people safe. In addition staff were clear on how to raise concerns with external agencies such as the local authority.

A number of safeguarding concerns had been raised by healthcare professionals who visited the home and the registered manager had completed thorough investigations to see if any changes were needed to keep people safe. However, we saw one safeguarding noted that the registered manager had not reported on-going concerns about a person's distressed behaviour and the impact that it had on them and other people living at the home. We discussed this with the registered manager. They told us while they had taken action to help the person manage their behaviour and to keep others safe, they had not realised that each incident had needed reporting to the local safeguarding authority.

People told us that at times other people living at the home would enter their bedrooms. One family member told us, "I went in a few weeks ago and it was trashed. Christmas cards thrown everywhere, flowers thrown everywhere, things broken. So I ask if her room could be locked when she's not in there but not when she's in the room. Sometimes when she's been ill and I've been here they've wandered in." We discussed this with the registered manager who told us they had moved rooms about so that the people who liked to walk about were all together in one area of the home. However, this did not resolve the problem only relocate it to one area of the home. Care plans did not identify going to people's rooms as a risk and there was no plan in place to manage this behaviour and protect both the people walking around and those whose rooms they went into.

While behavioural risks were not identified or planned for in the care records other standard risks to people had been identified. For example, records showed risks had been identified around pressure area care and mobility. In these cases the care records did include the information staff needed to keep people safe.

Staff knew the care people needed to manage these risks effectively and we saw the care they provided was effective. For example, one person who had been admitted before Christmas had a pressure ulcer and had been unwell. The home had liaised with the district nurse who had upgraded their pressure mattress. The person's pressure ulcer was now healing. Another person was nearing the end of their life and was being cared for in bed. As a result of this they had needed an upgrade of their pressure relieving equipment.

The registered manager had taken action when incidents and accidents had happened to reduce the risk of a repeat occurrence of the incident. For example, we saw one person had fallen when getting out of bed and grab rails had been put in place to help the person stay safe.

People told us there were enough staff to meet their needs, one person said, "There is always enough staff, staff are brilliant from top to bottom." People told us that staff responded quickly when they needed assistance. One person said, "Oh yes always I've got a buzzer here. All I've got to do is press that. They don't keep me waiting long." We saw that the buzzer within easy reach for them." Another person told us, "There always seems to be enough there to cope with everything."

The registered manager told us they had not used any tool to help them identify the number of staff needed. However, they had looked at how quickly they were able to respond to people and had recently employed

an external consultant to review the care provided. The consultant had advised an increase in staffing levels and this had been put into place. In addition, the registered manager told us that they had reviewed the job roles in the home and taken non caring jobs, such as the laundry, away from the care staff so they could focus on providing care. At busy times in the home such as mealtimes, when a lot of people needed support at the same time, the registered manager and other people in the management team provided addition support for the care workers. The registered manager had completed the appropriate checks to ensure staff were safe to work with people living at the home.

Requires Improvement

Is the service effective?

Our findings

We saw that the provider had made some efforts to design the environment to support people living with dementia to be more independent. For example, they had painted the toilet doors a red colour and had dementia friendly picture signs on the toilet doors. However, there was little evidence in the surroundings of other dementia friendly resources. There was a lack of items and images that might stimulate those with dementia or that would engage those prone to walking with a purpose. The décor around the home was functional but basic, this could be seen as lacking appropriate dementia friendly context.

Some of the bedroom doors had signs which indicated the person's name with a picture. However, this was not evident on all doors and not presented in a way which stopped people with dementia from removing them. Apart from the toilet doors there was a lack of signage that might support those living with dementia to be more independent.

One member of staff told us that they had started at the home as an apprentice and had gone on to be employed by the service when their apprenticeship finished. They told us they had received a good induction to the home which included shadowing more experienced members of staff and completing training. As part of their apprenticeship they had completed a nationally recognized qualification and had also completed the care certificate. The care certificate is a national training programme that provides staff with the skills needed to care for people safely.

Staff told us that they had lots of training which covered mandatory areas such as first aid, fire safety, food hygiene and supporting people to move safely. In addition to the care staff the registered manager had required kitchen, maintenance and housekeeping staff to do elements of the care certificate because they interact with people living at the home on a daily basis. In addition to the mandatory training needed to keep people safe training was provided in key areas such as dementia, challenging behaviour and Parkinson's. This supported staff in understanding people's needs.

The registered manager had been creative in accessing training for staff. This had allowed them to provide a number of face to face training sessions by contracting in companies who provided equipment and medicines. In addition, the provider had a range of online training that was available for people. The registered manager was supporting staff to develop their skills and identified that one member of staff would complete some 'train the trainer' courses so that they could provide training for new staff. There was a training plan in place for the year covering subjects such as dementia, dignity in care and stoma care.

The provider's policy was that staff should receive six supervisions a year. While everyone we spoke with told us they felt supported in their role, they had not all received the identified number of supervisions. We discussed this with the registered manager who told us that they had identified this as a concern and had put plans in place to ensure that staff received their supervisions on a regular basis. Annual appraisals had been completed.

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 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.

Staff we spoke with had a clear understanding of the Mental Capacity Act 2005 (MCA). One member of staff told us that it meant if people had capacity to make decisions then their choices should be respected. For example, if they choose to refuse their medicines. Staff were also clear that if people lacked capacity then best interest decisions needed to be made. They were also clear that healthcare professionals and family members should be involved in making these decisions.

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. The registered manager had appropriately completed applications for DoLS assessments for people who were unable to make a decision about where they lived. No one living at the home had a condition applied to their DoLS authorisation.

People told us that they were happy with the food offered and that they were given choices about their food. One person told us, "The food, I've no complaints, it's always well cooked." People were offered snacks and drinks through the day. We saw one person was offered biscuits or fruit with their drink. The member of staff ensured that the person was able to peel and eat their fruit before leaving them. Care plans recorded people's abilities around independence with food. For example, one person's care plan recorded that they could eat independently if offered finger food.

People who were at risk of being unable to maintain a healthy weight had been identified and appropriate support from healthcare professionals had been sought. People were given the right adaptive equipment they needed at mealtimes in order to eat independently. For example, one person was given a plate guard to enable him to eat his lunch. Where people needed to support to eat and drink care workers were encouraging and took their time to ensure the person had enough. This included when people found it difficult to sit and eat a whole meal. For example, we saw one person got up and walked to another table and staff followed them with their plate of food.

People told us that staff ensured they accessed healthcare professionals when needed. One person told us, "They ring up [the doctors] straightaway. They're very good that way. They get on the phone straight away."

Individual care plans included all the information needed to support people's day-to-day health needs. Additionally, we saw people had been supported to arrange and attend for eye tests and their prescriptions had been updated where necessary. Records showed other health professionals such as GP's and the community mental health team had been included in people's care when needed.

Good

Is the service caring?

Our findings

People told us that staff looked after them well. One person said, "I've never got the idea that they think I'm a bit of a pain. They always help, I just say what I need and they help They always get close so that I can hear them." Another person told us, "Everybody seems to know what I need. If there's anything extra I just mentioned it and they do it."

We saw that staff were caring and kind to people taking the time to ensure people felt well looked after. One member of staff told us, "They all need to know that we care about them." We saw staff laughing, smiling and chatting to people who lived at the home and their family members. For example, at lunchtime one member of staff gave a person a gentle hug and asked if the person would like an apron. The person put their arms around the member of staff and told them that they loved them and the staff member responded in kind. We saw that staff were good at taking the time to get the person's attention and to make eye contact with the person before asking them to do anything.

Even when staff were busy they kept an eye on what was going on and noticed if people needed support. For example, we saw one member of staff noticed that person had not had a drink. We saw that they offered a variety of drinks before the person chose one. However, we did note that despite all the staff helping to support people at lunch some people who needed help still experienced a wait for up to half an hour from when others began to eat.

Care plans included information on how people could be supported to remain independent. For example, one care plan recorded the person could complete some personal hygiene tasks if they were given clear instructions and encouragement. We saw staff encouraged people to be independent. For example one member of staff supported a person to be independent by helping them hold the cutlery. When the member of staff moved away the person continued to eat independently. Staff also knew how to support people with limited sight to be independent. When the member of staff gave them their meal they explained the food on the plate and where it was positioned so that the person understood what they were eating.

People's care plans showed that people had various ways of communicating. For example, one person would often shout out and this was not in distress rather as a means to communicate. Their care plan noted that they responded well to touch in addition they liked to be read to and would find that comforting.

Care staff noticed when people needed support to maintain their dignity. For example, we saw one member of staff discreetly helped a person to pull their skirt lower on their knees. In addition, they were responsive when people raised concerns. For example, on person indicated they were cold sitting at the tea table. A member of staff immediately went to fetch a cardigan for this person.

People were offered choices about their daily lives, what they wanted to wear, where they wanted to spend time and what they wanted to eat. An example of this was a member of staff who when escorting a person into the dining room asked them where they wanted to sit. Where people were not able to make choices staff understood their likes and dislikes. For example, we saw the cook speak to one person and their family

member about the menu for the next day and although they offered a choice they clearly knew what the person would like and their family member agreed.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with told us they were happy with the quality of care they received. A relative told us, "It's a fabulous place, when she left hospital she could not walk and staff took time to get her up. She is happy and so are we." However, people told us that they had not always been involved in planning the care they needed. We asked one person if they had been involved in planning their care and they told us, "No I've not but I did get involved in the end of life thing; I had to sign it. They usually do the paperwork."

Care plans did not record the person centred care people needed. We saw for two people in the home for respite care there was insufficient information recorded in their care plans to support staff to provide safe care. An example of this was a person who had been at the home since 19 December 2016. There were no care plans available and just one risk assessment regarding falls. The basic information collected at the preadmission assessment showed that the person had pressure ulcers and a history of falls. The assessment recorded that the person was mobile but staff told us they had been in bed since admission and did not mobilise at all which increased their risk of pressure ulcers. This was not documented anywhere in the care plan.

We also saw that for people with long term medical conditions the care plans did not contain the information staff needed to help them manage their conditions. An example of this was a person who had epilepsy which was controlled by medicines. There was no care plan to guide the staff in providing appropriate care if the person had a seizure. We also found that for people living with diabetes there was no specific care plan in place about diabetes and no guidance on actions staff should take if the person had low or high blood sugar.

There were a number of people living at the home who would walk around without apparent purpose. At times they would go into other people's rooms and take things. The registered manager had arranged for these people to have rooms near each other so that it was a more manageable situation and better for all the people living in the home. We saw one person's Deprivation of Liberty Safeguard (DoLS) authorisation noted they would enter people's rooms and needed to be constantly supervised. However, there were no care plans in place to support staff to manage this behaviour and no planned activities which could be used to help the person to be more settled.

This was a breach of regulation 9 of the health and social care act 2008 regulated activity regulations 2014.

We spent time speaking with staff and saw that they knew people and their needs well. Staff could tell us how they personalised the care they provided to make life calm and comfortable for people living at the home. An example of this was one person who was resistant to changing their clothes on a regular basis. Instead of directly asking the person to change their clothes, staff discussed other aspects of personal care with them and the person then calmly accepted support to change their clothes as part of the process.

Personal care was also provided to keep people safe. An example of this was one person who was at risk of developing pressure ulcers. Staff encouraged the person to get up and go for a walk at regular intervals

during the day to relieve pressure and help them stay healthy. Staff we spoke with understood why this was important and how the walks related to pressure care.

There was an activities coordinator employed at the home who worked three days a week. They were in the process of creating an activities profile for each resident which detailed their likes and dislikes, mobility and communication. They told us about the variety of activities they offered which included knitting club, jigsaws, exercises sessions and reminiscing. In addition other activities such as singers and exercise were provided by external agencies.

Staff told us that they would encourage people to go to the communal areas when there was entertainment planned. However, some people would choose to stay in their rooms. Staff told us that they had time to spend with people and that people would look at photos and talk about their lives. One member of staff told us that they would come in on their days off so that people could access the community.

Several of the people living with dementia had comfort mitts on their knees which they engaged with. However, there was little evidence in the surroundings of other dementia friendly resources. There was a lack of objects and images that might stimulate those with dementia or that would engage those prone to walking around.

Records showed where people wished to practice their religious beliefs the staff supported them to do so. For example, one person liked to see the local vicar each time they visited and would have communion in their room.

People told us they knew how to complaint but that they never needed to as staff were responsive to their needs. One person told us, "I can't just think of anything, they're always prepared to help where they can and between us we resolve the problem." We saw there was a notice telling people how to complain in the main entrance. Relatives we spoke with said they knew who to go to if they had any worries or complaints. They felt the registered manager had a strong presence and was often seen about the home and could go to them with any issues. We saw complaints had been thoroughly investigated and actions identified to keep people safe.

Requires Improvement

Is the service well-led?

Our findings

This was the second inspection for the home where they had received a rating. While the provider and registered manager had taken enough action to ensure that the care provided was meeting the legal requirements they had not made enough progresses to increase the rating from requires improvement.

The registered manager had a set of audits in place to monitor the quality of care people received. For example audits had been completed in infection control and medicines. In addition members of the management team completed daily walks around the home. They would check if people's rooms were clean and tidy and speak to people about the care they received to gather feedback about what was working and what was not. The local authority had visited the home in October 2016 and been happy with the standard of care provided.

However, during our inspection we found a number of areas where the care provided did not meet current best practice guidelines and improvements were needed. We found that care plans did not reflect the care that people needed. We also found that systems around the administration of PRN medicines were not robust enough to support people to be offered these medicines consistently. The environment did not fully support the needs of people living with dementia and activities were not provided to help people be settled, calm and contented.

We recommend that the provider and the registered manager review the good practice guidelines for long term conditions and to support people living with dementia.

People told us that the registered manager was approachable and would help to resolve issues. One person told us, "I could talk to her. On the first time I came in she sat with me for ages and we've always got on." A family member said, "If I've got any concerns I will go upstairs and knock on her door."

Staff told us that the home was a good place to work, and that the staff supported each other to care for people living at the home. They told us that they were developing their approaches and felt that they were delivering the individual care each person needed. They told us that the registered manager was approachable and that they could raise any concerns with the registered manager and they would listen and take appropriate action. Staff were supported with regular team meetings and individual supervisions which gave them opportunities to raise concerns with the management team.

Records showed surveys had been completed together with gathering the views of people living at the home and their families. The registered manager had reviewed the surveys and had taken action to respond to individual concerns. In addition they had analysed the findings into key areas to improve the care provided. For example, they had developed more activities.

The registered manager and provider had engaged with external agencies to improve the quality of care they provided. The registered manager was taking part in the harm free care project run by the local authority. This project looked at preventing pressure ulcers and keeping people safe from falling. Two

members of staff attended the local authority infection control meeting. The provider had contracted with an external agency who completed routine health and safety checks on the home. They had also worked with an external consultant to look at the quality of care provided for people and any improvements that could be made.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that care was designed to be appropriate and to meet people's needs. People were not involved in designing their care. Regulation 9 (1) (3) (a)(b)(c)