Abbeyfield Society (The)

Victoria House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Victoria House Residential Home is a residential care home providing personal care up for up to 30 older people some of whom may have dementia. There were 21 people living at the service at the time of the inspection.

People's experience of using this service and what we found
People using the service and their relatives had mixed feedback in relation to people's safety and care approaches at the home. Some relatives felt people using the service were not safe. Our observations and findings showed people did not always receive safe care and treatment. Risks to people's health and wellbeing were not always sufficiently monitored and managed. Records of care did not accurately indicate the support provided to people. Guidance to staff on what actions they were to take to manage risks was not always available or individualised to ensure each person received care suitable to their needs. Risk management in relation to nutrition and hydration and pressure care needed to be improved.

People were not supported by adequate numbers of suitably qualified staff to reduce the risk of harm. Not enough staff were deployed to meet people's needs. There was a lack of clarity on how caring responsibilities were assigned to staff to ensure people received care when required.

The governance systems at the service were not adequately implemented to protect people from risks, to promote a person-centred approach and deliver safe and high-quality care. Audits did not always identify the shortfalls we found. In addition, audits were not always used to address shortcomings in a timely manner and some had continued since our last inspection.

Staff provided mixed responses in relation to the culture and management style; particularly from head office. Staff morale was low and agency cover was not always valued. There was a lack of robust oversight to ensure risks to people were continually monitored to prevent deterioration. There was an ongoing high turnover of managers which could affect development of community links with local health and social care services and the running of the home.

People's care records did not always reflect the nature of care provided. Staff did not always maintain accurate records which may hinder the support and delivery of safe and person- centred care.
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 Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection and update

The last rating for this service was inadequate (published 7 April 2022).

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the provider remained in breach of regulations.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

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.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

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 remained inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Victoria House on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified continued breaches in regulation in relation to safe care, staffing and good governance at this inspection. The registered provider took immediate action to address some of the concerns and improve people's experiences.

Please see the action we have told the provider to take at the end of this report.

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 overall rating for this service is 'Inadequate'. The service remains in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures. This means we will keep the service under review and, if we do

not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe, and there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Victoria House

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
Two inspectors and an Expert by Experience carried out the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Victoria House 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 House 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 service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service, including information from the registered provider about important events that had taken place at the service, which they are required to send us. We sought feedback from the local authority.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
We spoke with five people using the service and four relatives about their experiences of the care provided. We spoke with 10 members of staff including the manager, the regional manager, head of care, maintenance person and care staff. We also spoke to the nominated individual for the service. A nominated individual is responsible for supervising the management of the service on behalf of the registered provider.

We reviewed a range of records. This included 14 people's care records, various medication records, accident and incident records, two staff recruitment records, staff files and we looked at a variety of records relating to the management of the service.

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.

Inadequate

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 inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● People were not adequately protected from the risk of avoidable harm because arrangements for monitoring and reviewing risks were not robust.
● Risks to people were not well managed. Actions required to reduce risk to people had not always been carried out despite risk assessments being in place for areas such as nutrition risk. For example, staff did not consistently and or accurately maintain hydration charts to monitor people's fluid intake when required which posed them to a risk of dehydration and deterioration of their health.
● Risk management plans were not always followed to ensure people were supported safely. For example, one person who had been assessed as requiring hourly checks did not always get checked as planned and care records linked to this were not maintained or incomplete.
● Managers did not always check if staff were taking action to monitor if further intervention was needed when people's health declined. For example, an incident occurred after a person had been observed to be 'disoriented' which would require monitoring of their well-being. This was not done which may have led to the person's deterioration resulting in harm.
● The provider did not ensure staff understood how to support people in adverse weather conditions. Staff did not always have sufficient guidance on managing risk. On both days of our inspection, there was a heatwave and temperatures rose to levels which could cause serious injury or death to people using the service.
● We observed, sun facing bedrooms had their curtains open and the room temperatures were very high. Temperatures particularly of these rooms were not consistently checked and monitored which put people at risk of avoidable harm. The provider failed to ensure people's individual needs in relation to the heatwave were identified. There was a failure to follow national and local guidance in the event of a heatwave. Staff had generalised national guidance to support people during a heatwave including offering fluids to people. However, staff we spoke with did not have an understanding of the effects of heatwave including the probability of heatstroke and likelihood of death.
● We spoke with the nominated individual who told us of their monitoring systems. They emailed us some guidance. However this was not readily available to staff nor individualised at the local level to mitigate the

risk of harm to people. For example, some people had fans in their rooms to help with cooling. However, these were not always turned on.
● We also raised this issue with the manager who told us they were encouraging people to increase their water intake and offering lollies. The manager acknowledged the oversight in having effective management systems in place such as individual risk assessments and monitoring temperatures in people's rooms.
● Incidents were not always analysed nor reports completed to show what actions had been taken to reduce the incident from happening again. For example, a person had suffered a fall and there was no review of this for staff to learn lessons.

Systems and processes to safeguard people from the risk of abuse
● People were not protected from the risk of abuse as staff did not always take appropriate action to safeguard them. For example, care records showed a person had an unwitnessed fall which led them to be admitted into hospital prior to staff observing them as appearing 'confused'. There was no further information recorded on what action staff undertook to support the person such as checking for urinary tract infections or any issues that my cause them to be confused.
● Staff were trained in safeguarding adults. However, systems were not robust enough to ensure they received the support they required to minimise the risk of abuse to people.

We found evidence people were exposed to risk of avoidable harm and systems were either not in place or robust enough to demonstrate their safety was effectively managed. Not enough improvement had been made at this inspection and we identified further areas of concern.

These issues are a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment
● We received mixed responses from relatives regarding the staffing levels in the home. Some relatives told us they felt staffing levels were not always enough to keep people safe. Others considered the staffing levels to be adequate to support people safely.
● Similarly, staff indicated that staffing had improved since our last inspection. However, good practice was still embedded as additional permanent and regular agency staff were employed.
● We remained concerned about staffing levels as the registered manager routinely undertook care tasks and administered medicines. This took them away from their role to effectively monitor the service and this may have contributed to a lack of appropriate action to remedy the failings identified throughout the inspection. There were not enough staff trained to administer medicines.
● Staff did not always arrive on time, permanent staff as well as agency, so at times there were not enough staff on the premises.
● The provider had a system for determining people's needs and staff numbers including duty rotas. However, we found the dependency assessments were not always accurate to support the correct deployment of staff.
● The allocation of duties to care staff was not robust enough to ensure accountability and to know which member of staff was responsible for providing care to particular people. Allocation sheets were not always accurate, did not reflect all staff on duty and staff were left to decide what tasks to undertake.
● For example, one incident record stated that there was to be a staff member in the lounge at all times following an unwitnessed fall of a person using the service. No member of staff was allocated to cover observations across the two lounges and dining rooms in the morning when some people needed double up care or when people chose to spend time there.
● We were not assured of the safe recruitment of staff. We checked two files of staff recruited since our last

inspection. One file did not contain any references and both were not issued with ID badges in line with the provider's procedures.

Not enough improvement had been made at this inspection. There was a failure to deploy adequate numbers of suitably qualified staff. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The provider had an ongoing recruitment programme to recruit and retain staff and reduce the use of agency staff. Regular agency staff were being brought in to cover absence and sickness.

Premises and environment
● People lived in an environment that continued to pose a risk to their safety and well-being.
● The provider had embarked on a refurbishment programme to ensure premises were safe and in good condition. Some of the issues we found at the previous inspection were resolved. This included, making the grab rails safe, fixing leaks and a hole in the ceiling. Fire doors had been replaced. The area leading to the staff area had been cordoned off to allow repairs to be undertaken. Staff kept the door to the laundry closed to minimise the risk of people who walked with a purpose ingesting laundry chemicals. The broken chair lift had been fixed.
● We sought feedback from the nominated individual about the outstanding works which included replacement of external doors. They told us the purpose made doors had been ordered and were awaiting delivery. We will check this at our next inspection.
● At our previous inspection, staff were not aware of how to support people safely in case of an emergency. At this inspection, staff told us they had received training and discussed emergency procedures for keeping people safe in the event of a fire. They felt confident of their preparedness to respond in case of a fire and emergency evacuation.
●The provider had taken action to ensure staff understood how to support people safely in case of an emergency by providing training and discussions in team meetings.

Preventing and controlling infection
At the last inspection, the provider failed to ensure infection prevention and control procedures were implemented consistently and robustly. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At this inspection, the provider had not taken sufficient action to ensure people lived in a clean environment.
● We were somewhat assured of the provider's action to prevent cross contamination and infection. Not all aspects of the home were kept tidy, clean and safe. The dirty and broken cat flap door remained and was scheduled to be replaced as part of the planned replacement of all external doors. There was a telephone box open with wires which caused a trip hazard, a greasy bedroom door, shoes on a weighing scale, a bottle of sanitiser used as a window prop and grubby grout in a bathroom. There was still work required to keep all aspects of the service clean.
● People were not always protected from the risk of infection and contamination. The registered provider had systems to enable staff to minimise the risk of infection. Improvements showed the systems were in place but staff had not embedded good practice in their work. Staff we spoke with knew what good hygienic practices looked like.
● Comments from people using the service and their relatives on cleanliness at the service were positive and said things had improved since the last inspection. We observed most aspects of the home to be generally clean.

● Staff did not consistently wear face masks and we observed some walking about without or below their noses. Some hand sanitiser dispensers were empty or broken and we did not observe any member of staff using these. Staff wore gloves and aprons when undertaking personal care and supporting people to eat and drink.
● The provider had recruited domestic staff to cover weekends and to ensure consistent cleaning of the home to minimise the risk of cross contamination and infection.
● Arrangements were in place for testing visitors and staff and new admission into the home.

Using medicines safely
● People's medicines were administered safely or as prescribed. Staff followed safe and best practices in medicine management, storage and administration.
● Medicines administration records were accurately completed.

Visiting in Care Homes
● Arrangements were in place for testing visitors and staff and new admission into the home.

Inadequate

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 inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care;

At our last inspection the provider had failed to adequately assess, monitor and improve the quality of service provided for people using the service, which could potentially impact on their safety and wellbeing. Systems needed time to embed. This is a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The provider has been in breach of regulations 12, 17 and 18 since the previous inspection. Systems were not effectively used and resulted in the provider failing to achieve and maintain compliance with regulations.
● The provider had introduced changes after our previous inspection including a new registered manager and increased support for local management. However, the registered manager left a week before this inspection and an interim manager was appointed, who we were then informed left after our visit. We noted with concern a continued high turnover of managers at the service.
● The provider had introduced additional governance and quality monitoring systems to monitor and improve the care provided. We found these had not been fully embedded. They were not effectively monitored to respond to ongoing risk to people such as record management, care planning and staff training.
● Management did not ensure the systems were robustly used to ensure staff had sufficient knowledge and skill to meet the needs of people using the service and to promote high quality and person-centred care. The inconsistency of day-to-day management of the home resulted in a lack of oversight and impacted care delivery.
● The provider lacked sufficient oversight of the manner in which staff provided and monitored care which meant increased risk and the likelihood of deteriorations in people's health. Risks were not adequately monitored and responded to.
● Quality of care was not being adequately monitored. Daily records and room logs to check visits by staff were not consistently recorded. Some relatives contact details were incorrect on the list we were given.
● We were not assured the provider's system for promoting continuous learning and improvements were adequately supported in view of the practices in place. For example, shortfalls identified at the previous

inspection were not resolved. This included ineffective monitoring of recording of care provided to people. Food and fluid intakes were not always and sufficiently recorded which meant the provider could not always assess people's health and make timely interventions. Out of date posters were displayed at the premises from May 2020 and a poster about COVID-19 rules from 2020 when overseas travel was restricted.

● Systems for learning from incidents and near misses were in place but not robustly and consistently applied. For example, some incident reports were not completed, or clearly filled and were not always reviewed by senior staff, registered manager or managers from head office. These were missed opportunities in checking any trends or patterns or reviewing whether adequate numbers of suitably qualified staff were deployed to support people with additional needs.

There continued to be a failure to assess, monitor and improve the quality, safety and welfare of people using the service and others who may be at risk. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● We received mixed feedback from staff regarding the culture and management's ability to respond to staff suggestions, improving the service and their relations between them and head office managers and turnaround of the service.

● Staff in the majority shared positive feedback regarding the registered manager and the manager; both of whom have since left the service. They felt managers from head office were not always supportive and did not take time to understand the challenges prevailing at the service. We shared our concerns with the nominated individual during the inspection.

● In addition, staff raised concerns regarding the sharing of information with managers during out of hours when they sought additional guidance. We saw and received evidence of how this had impacted or may impact on the delivery of safe and effective care as staff felt unease to contact managers out of hours.

● Staff morale was mixed and we observed some eagerness to do the right things but lacking robust direction from management. Other staff were clearly not interested in ensuring the service improved. Staff did not always work well together.

● Some relatives told us they had not been involved in the review of care plan and said this could be because of lockdown. Other relatives told us staff involved them and communicated with them when issues arose or to review care plans.

● Records were not maintained well and not always stored securely. For example, two sets of notes were left out in communal areas; on the landing and in the dining room. People's files were not always labelled. Audit records were incomplete and not always found when requested during the inspection. The manager was not able to retrieve documents in a timely manner.

● The provider worked with healthcare professionals within the local area.

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;

● The provider was aware of their responsibility to notify CQC of significant events and work closely with the safeguarding adults authority and the local clinical commissioning group in line with local reporting arrangements and statutory requirements.

● The head of care showed an unwillingness to support the manager and the inspection process although they had worked at the service for years. The list of staff was not up to date and showed those who had left the service and without some names of recent recruits or agency.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure care and treatment was provided in a safe way for service users and failure to assess the risks to the health and safety of service users of receiving the care or treatment; including doing all that is reasonably practicable to mitigate any such risks; Regulation 12

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were not robust and there was lack of robust oversight on the regulated activity. The registered provider had failed to assess, monitor and improve the quality and safety of the services provided. The provider failed to establish systems and processes to enable them to identify where quality and/or safety was being compromised and to respond appropriately and without delay. Regulation 17

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

The provider failed to ensure staff received suitable training and support to undertake their roles and responsibilities.

Regulation 18