Supreme Care UK Ltd

Victoria House Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate

Overall summary

We carried out an unannounced comprehensive inspection of this service on 31 July and 7 & 14 August 11 2015. Breaches of legal requirements were found. After the comprehensive inspection, we issued the provider with a warning notice in relation to Regulation 12. We told the provider they must take action to ensure they met legal requirements by 9 October 2015.

We undertook this focused inspection on 15 October 2015 to check the provider had met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Victoria House Care Home on our website at www.cqc.org.uk

Victoria House Care Home provides accommodation and personal care for up to 26 people who are older or who are living with dementia. Some people had health needs such as diabetes, and others needed support with their mobility. There were nine people living at the home at the time of our inspection.

The home did not have a registered manager, although a new manager had been recruited and was due to start employment in November 2015. A second interim manager was running the home at the time of this inspection. 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.

Risks to people's safety were not properly assessed. Examples included risk of malnutrition and risk of developing a pressure wound. Not all of the appropriate action had been taken since the last inspection when risks to the property had been identified, for example fire safety and legionella. The provider did not have a suitable schedule to ensure maintenance tasks were completed

Summary of findings

when required. Incidents and accidents continued to be inconsistently documented and investigated. Appropriate action was not always taken to prevent incidents from re-occurring.

Although staffing levels had improved. People's care needs had not been assessed to establish what the appropriate number of staff on duty should be. We found several occasions where staff left for breaks together leaving only two staff to support people.

People's medicines were not safely managed. People did not always receive their medicines as prescribed. People continued to be given medicines regularly when they had only been prescribed it on an as and when needed basis. Medicines administration records remained incomplete so it was not possible to establish if people had received their medicines.

People remained at risk of not having their hydration needs met. Although fluids were readily available for people, individual's fluid intake was not always properly monitored. People had not had their risk of malnutrition assessed, and appropriate action had not been taken for a person who had been identified as losing both their weight and appetite.

We found continuing breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Care Quality Commission is currently considering the appropriate regulatory response to resolve the problems we found.

Summary of findings

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 

People's medicines were not managed safely. Some people had not received their medicines as prescribed.

People's safety was not protected because there were not always enough staff deployed to meet their needs.

Risk assessment and risk managements practices were inconstant. Individuals did not have the risks to their health and safety properly assessed or managed. Identified risks to the environment had not been fully rectified.

Incidents and accidents had not been properly analysed to ensure risks to people's safety were minimised.

Victoria House Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements of Regulation 12 associated with the Health and Social Care Act 2008 and the Care Act 2014.

We undertook a focused inspection of Victoria House Care Home on 15 October 2015. This inspection was completed to check that improvements to meet legal requirements after our comprehensive inspection on 31 July and 7 & 14 August had been made. We inspected the service against one of the five questions we ask about services: is the service safe. This is because the service was not meeting legal requirements in relation to this question. The inspection was undertaken by two inspectors.

During the inspection we spoke with four people who used the service and a person's relative. We spoke with the provider, the interim manager and five members of care and administration staff. We looked at three people's care records and risk assessments, all of the medicines administration records (MAR), and records relating to the maintenance of the building and equipment. Before the inspection we spoke with the local authority safeguarding team.

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Is the service safe?

Our findings

At our comprehensive inspection of Victoria House Care Home on 31 July and 7 & 14 August 2015 we found that people were not safe. This was because the provider did not identify, assess and manage risks relating to the health, welfare and safety of people who use the service and others. This included unsafe medicines management, poor risk assessment, inadequate staffing levels and unsafe management of the premises. These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this focused inspection we found safety issues that were identified at the comprehensive inspection had not been sufficiently improved and people's medicines were still not managed safely.

People did not always receive their medicines as prescribed. One person had their medicines dosage increased by their GP, but this was not administered by staff for four days. Another person had not received a medicines dose, even though it had been signed for as administered by staff on the person's medicines administration record (MAR) chart. Two people did not receive their medicines because they were dropped on the floor and staff did not notice at the time so both people did not receive their medicines as prescribed. One person had declined to take one of their medicines for two weeks. The provider had not made a referral to the person's GP or discussed the possible side effects of not taking the medicines with a health care professional.

Some people were prescribed medicines 'as required' (PRN) by their GP. People took these medicines only if they needed them, for example, if they were in pain. A care plan was not in place to advise staff on how to identify when a person was in pain. Clear instructions were not given on when and why these medicines should be administered. PRN medicine had been included in one person's daily medicines and were being administered routinely twice a day. No consideration was being given about whether the person needed the medicine or not, or if the medicine might be needed at different time of the day.

MAR charts were not always completed when people received their medicines. There were gaps in all of the MAR charts we reviewed, with no explanation of why, so it could not be established if the person had received their medicines or not. These errors had been identified by staff, but no action was taken by the provider to ensure these mistakes were not repeated.

Training for staff in medicines administration remained poor. None of the staff had been supported to complete training in the safe administration of medicines and their competency to administer medicines had not been assessed since the last inspection in August 2015.

A legionella risk assessment had been completed on 18 March 2015 and the home had been assessed as at high risk for legionella bacteria. At the last inspection the provider was unable to demonstrate that appropriate action had been taken to protect people and others from the risks associated with legionella bacteria. On 1 September 2015, the provider sent a sample of water to be tested for legionella bacteria to a specialist company. The water sample tested positive for a legionella bacteria which was not harmful to human health. However, the company had advised the provider to pasteurise the water system to ensure that harmful bacteria did not develop. The provider was unable to provide any evidence to demonstrate this work had been completed and was not aware of the presence of the non harmful bacteria.

Other actions which had been previously recommended in the March legionella risk assessment continued to be incomplete. This included testing the temperature of the stored water, temperature testing at water outlets and regular de-scaling of showerheads and taps. People's health and safety remained at risk because the provider was still unable to demonstrate that appropriate action had been taken reduce the risks associated with legionella bacteria.

At the last inspection we found people were not well supported with their hydration needs. At that inspection, we did not observe people being offered drinks except at lunch time and jugs of water and glasses were not available for people who were in their rooms. At this inspection more fluids were available for people, and we observed people being supported to drink more. People's fluid intake was being monitored and charts had been introduced to record what people had to drink. However, these were not being used safely for every person.

One person had their recommended fluid intake calculated from their body weight. However, the person's

recommended body weight and not their actual weight was used to calculate what the person's safe intake of fluids should be. The person's fluid intake was not always totalled at the end of day. The person's fluid charts showed they had not had the correct recommended intake for eight out of 11 days, which had not been identified by any staff. Hydration risk assessments had not been completed for people. Although some action had been taken to reduce the risks associated with poor fluid intake, people's safety remained at risk because the provider had not fully assessed the risks to people's health due to lack of hydration.

People's safety was put at risk because risk assessment and risk management practices at the service were not consistent. While some people had appropriate risks assessments in place others did not. For example, one person's mobility had significantly decreased, and they spent a lot of time sitting in a chair. They were unable to mobilise independently and relied on staff to help them go to the toilet. A pressure damage risk assessment had not been completed to assess the person's risk. This meant a management plan was not in place to reduce the risk to the person's health and safety.

At the last inspection we identified that people did not have their risk of malnutrition properly assessed. Where people had been losing weight, this had not been noted or acted on by staff. At this inspection we found people continued not to have their risk of malnutrition assessed. This included appropriate action not being taken for a person who had been identified as losing both weight and their appetite. The provider had not assessed the risks of malnutrition to the health and safety of people using the service.

At the last inspection we found there were not enough staff. At this inspection, although staffing numbers had been increased to four per shift, the provider had not appropriately assessed people's care needs. Some people required the support of two care workers to move from their bed to their chair or to go to the toilet. This had not been considered by the provider when determining staffing levels. We also observed several occasions when two staff left for a break at the same time which left only two staff to support people. If both members of staff were supporting one person, there were no other care workers available to help other people if they needed it. The provider had not assessed the risks to people's safety, and had not taken reasonable action to mitigate the risks to people's safety due to lack of staff.

Incidents and accidents continued to be poorly investigated and appropriate action was not always taken to prevent incidents from happening again, for example, when medicines were found on the floor. Although these incidents had been recorded, they were not fully investigated. Action that could be taken to prevent a recurrence had not been taken, and people remained at risks of their medicine being dropped on the floor. There was no evidence on file to show that learning had taken place as a result of these incidents. On another occasion a member of staff had noticed bruising on a person and had recorded this in the communications book. However, the bruising was not reported to or reviewed by a senior member of staff, so the cause of the bruising was not properly investigated. The provider was not doing all that was reasonable to reduce risks to people's safety, or ensure that care was provided in safe way for people.

At the last inspection we found some environmental risks had not been identified by the provider. This included rubbish in the garden and unlocked sheds containing items which may have posed a hazard to people or staff. At this inspection we found there had been some improvement in the garden. Tree cuttings, branches and broken furniture had been removed and the garden area was safer. However, the sheds in the garden remained unlocked and still contained cans of paint and broken furniture which may have posed a risk to people going into the shed. There was also old and broken equipment being stored in the side passages around the house.

At this inspection we found that essential maintenance tasks had been completed, and the relevant paperwork was up to date. This included servicing of the lift and hoists, and gas and electrical safety. However, the provider did not have an appropriate schedule to ensure essential maintenance was kept up to date in the future, for example, maintenance of the call bells was due in November 2015, which the provider was not aware of.

A fire risk assessment had been completed on 10 June 2015 by an external company and several risks had been identified, including missing smoke detectors, fire extinguishers not serviced and fire doors which did not comply with regulations. While the provider had taken

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Is the service safe?

some action to address these risks, including moving all of the people living in the home to the ground floor and servicing of the relevant equipment, other action which was reasonable had not been taken, including clearing a corridor of equipment. Although an estimate had been obtained for completion of the necessary work, the provider was not clear about work was required or when it would be completed by.

People did not have their care and treatment provided in a safe way. These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users. The provider did not assess the risk to the health and safety of service users or take action to mitigate such risks. Medicines were not safely managed. Regulation 12(1)(2)(a)(b)(g).

The enforcement action we took:
The Care Quality Commission is currently considering the appropriate regulatory response to the continuing breach of this regulation.