HC-One Limited

Victoria Park (Coventry)

Inspection report

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an inspection of Victoria Park on 17 and 22 May 2017. The inspection was unannounced.

Victoria Park provides accommodation with personal care for up to 32 people. There were 28 people living in the home at the time of our inspection. Some people were living with dementia.

A registered manager was in post. 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.

The service was last inspected on 28 July 2016 when we found breaches in the regulations in relation to supporting people who lacked capacity to make decisions, providing safe care and treatment to people and good governance. We asked the provider to take the necessary steps to ensure the required improvements were made. At this visit we found actions had been taken which had resulted in some improvements. This was in regards to working with people who lacked capacity and the management (good governance) of the home. However, we identified further actions were required to ensure the home consistently operated safely and effectively.

During our last inspection we found medicines were not consistently managed or administered safely which meant people did not always receive their medicines as prescribed. Following the inspection, we continued to receive reports in relation to concerns about medicine management. During this inspection we found continued concerns with medicine management, this was in relation to administration, storage and recording of medicines. The provider had not ensured sufficient action had been taken to ensure medicine management was safe.

During our last inspection we found improvements were needed to ensure staff understood the principles of the Mental Capacity Act and Deprivation of Liberty Safeguards and the need to ensure people consented to care. During this inspection we found the necessary improvements had been made. The provider had identified people whose care plans contained some restrictions to their liberty and had submitted the appropriate applications to the authorising authority in accordance with the legislation. Staff understood the principles of the Mental Capacity Act 2005 and sought people's consent before supporting them.

Overall, staff knew about risks associated with people's care and knew what they needed to do to keep people safe. However, it was not clear from records that risks were managed consistently to keep people safe. Accidents and incidents were recorded and the process to report these to CQC had improved. These were reviewed each month by the provider so they could identify any actions required to reduce the risk of them happening again.

People told us they felt safe living at the home and there were usually enough staff available to meet their

needs. People felt that most of the time, staff knew how to support them and staff told us they had received the training they needed to effectively meet people's needs.

Recruitment checks were carried out prior to staff starting work at the home to make sure they were suitable to work with people who lived there.

New staff received an induction to the home when they started their employment and received training based on the Care Certificate, to develop their skills to care for people effectively. There was a training plan in place to ensure all staff completed the required training, some staff were due to update their training.

Most people said they enjoyed the food and there were choices of drinks and meals provided. We could not be sure that people who needed to have their food and drink monitored, always had enough to eat and drink, as records were not always completed correctly. People were referred to health professionals to ensure their health and well-being was maintained and people told us they could access the doctor when they needed to.

People and their families were overall positive about the care provided by staff. Staff members demonstrated a caring approach towards people but some practices related to people's privacy and dignity were in need of improvement.

Staff supported people to make choices and some staff knew the people they cared for well. People were encouraged to maintain relationships important to them and staff recognised the importance of promoting people's independence.

Care records were sometimes not clear or sufficiently personalised to ensure people's preferences and needs were met. However, staff spoken with had a good understanding of people's preferences. There were staff employed to organise social activities and to provide opportunities for engagement and stimulation for people. Work was ongoing to ensure activities were suited to all people in the home. We observed people who participated in social activities enjoyed them.

The provider had systems and processes to monitor the quality of care and services people received although sometimes these had not been effective in ensuring actions for improvements identified were effectively carried out. People and their relatives had the opportunity to get together formally to feedback any issues or concerns. People knew how to make a complaint if they wished to do so.

Staff were positive about working at the home and felt the management team were approachable if they had any concerns. The registered manager had been in post for eight months at the time of our visit and was supported by the provider's management team to drive improvement at the home.

We found a continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 told us they felt safe and procedures were in place to protect people from harm. There were sufficient numbers of staff to meet people's needs. Medicines were not consistently managed or administered safely. It was not clear that risks associated with people's care were consistently managed. Incident and accidents were recorded, monitored and reported to help minimise the risk of them happening again. The provider's recruitment procedures ensured staff were recruited safely to the home.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Action had been taken to assess people's mental capacity and applications to deprive people of their liberty were made where this was in their best interests. New staff received an induction and staff training was ongoing to ensure staff developed their skills and knowledge. People had a choice of food and drink and staff had some knowledge of people's nutritional needs. Nutritional records were not always clear where people's food and fluid intake was monitored. People were referred to healthcare professionals when a need was identified.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People and their relatives were overall positive about the staff. People were supported by a staff team who were overall patient and treated people with kindness. Staff recognised the importance of promoting people's independence. People were encouraged to maintain relationships important to them. Sometimes people's privacy and dignity had not been maintained.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff overall were responsive to people's needs and some staff knew the people they cared for well. Staff supported people to make choices and a range of social activities were provided. Care plans required more information to ensure people received personalised care in accordance with their preferences. People had some involvement in planning and reviewing their care. There was a complaints process in place but this needed to be clearer. People felt confident to report any concerns and knew who to speak to.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

A registered manager was in post and overall people were positive in their comments of the management of the home. There were systems and processes to monitor the quality of care and services provided but these were not always effective. People, visitors and staff were encouraged to give feedback about the quality of service within the home.

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.

This inspection took place on 17 and 22 May 2017 and was unannounced. This was a comprehensive inspection.

The inspection was carried out by two inspectors and an expert by experience on the first day. An expert by experience is a person who has experience of using this type of service themselves or caring for someone who used this type of service. On the second day, one inspector and a medicines inspector returned to continue and complete the inspection.

We reviewed the information we held about the home. We looked at information received from agencies involved in people's care and spoke with the local authority commissioning team. Commissioners are people who contract services, and monitor the care and support when services are paid for by the local authority. They told us they had recently visited the home and were due to visit again to review updated care plans. We also spoke with a GP who provided support to the home. Issues they raised were similar to what we found.

We reviewed the information in the provider's 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. Information within the PIR mostly reflected what we found.

We analysed information such as statutory notifications received from the provider. A statutory notification is information about important events which the provider is required to send us by law. These can include safeguarding referrals, notifications of deaths, accidents and serious injuries. We considered this information when planning our inspection of the home.

We looked at four care plan records in detail and other associated documentation such as people's risk

assessments and medicine records. We looked at the complaints information, staff training records, accidents and incident records and quality monitoring information.

We spent time observing how staff interacted with people in the home. We spoke with five people who used the service, two relatives, two health professionals and ten staff members including the area director and the registered manager.

Requires Improvement

Is the service safe?

Our findings

During our last inspection to Victoria Park in July 2016 we identified medicines were not consistently managed safely. We could not be sure medicines were disposed of safely. This was a breach of Regulation 12 Safe Care and Treatment.

Following our last inspection the provider sent us an action plan outlining how they would make improvements. They told us medicine checks would be carried out daily and monthly. They said "spot" checks would be carried out of the medicine records. They also told us, "The management of topical creams will be reviewed and a robust system will be put in place."

During this inspection, we found the processes implemented to ensure the safe and effective management of medicines were not effective.

A medicines inspector visited Victoria Park on the 22 May 2017 after issues were identified with the management of medicines on day one of the inspection on the 17 May 2017. Following day one of the inspection, the provider had accepted the shortfalls identified and had ensured that all medicines were accountable for the start of the new medicines cycle on the 20 May 2017.

We looked at how medicines were managed by checking the medicine administration records for eight people, speaking to senior care staff member and observing a medication administration round. We found further issues with the administration records. For example, the system used to record the administration of warfarin (a blood thinning medicine) was not robust and was not able to show that the medicine was being administered as prescribed. Blood thinning medicines increase the risk of bleeding and therefore it is important to administer the correct dose and be able to confirm that the correct dose has been administered.

We found 11 doses missing from an inhaler which indicated the person may have received more than their prescribed dose.

An antibiotic eye drop that was to be administered for five days was administered for six days demonstrating these had not been administered as prescribed. The prolonged use of antibiotics can lead to bacteria resistance to the antibiotic so it is important that the antibiotic is used only for the period specified by the doctor.

We found three people had not been able to receive some of their medicines because they were out of stock and the provider had not made suitable arrangements to make sure they were available. For example, a medicine for one person had been out of stock for 10 days, and another, for three days. One of these medicines was for the treatment of constipation and when looking at the impact of the person not receiving their medicine for 10 days, we found the provider had not managed this problem appropriately.

We also found two examples of where the administration of the out of stock medicine did not commence

until the day after they had arrived, where it would have been appropriate for these medicines to have been administered on the day of their arrival. This meant treatment for people's health conditions was unnecessarily delayed. One of these examples involved the administration of a strong analgesic for pain relief and any delay would have increased the risk of the person experiencing unnecessary pain.

The provider was not always recording the location of where pain relief patches were applied to people's bodies. We spoke with a member of senior care staff about how the patches were being used. We found staff were not following the manufacturer's guidelines on rotating these patches around the body. This meant the patches were not being applied safely and could result in the person experiencing unnecessary side effects.

Medicines were not stored securely. We found topical medicines were stored in people's rooms without the appropriate security measures in place. This meant that people could potentially access and inappropriately use these medicines which could place them at risk of harm. We also found the administration records for these topical medicines were not able to demonstrate they were being applied in accordance with the prescriber's instructions. We spoke with a person who had been prescribed a pain relief gel for their knees. This person told us that their knees were painful and confirmed that their pain relief gel was being applied "once or twice" a day when it had been prescribed as a three times a day application.

The temperature monitoring of the two refrigerators that were used to store medicines were not being monitored correctly. This meant the provider could not demonstrate medicines stored in these refrigerators were being stored at the correct temperature, to ensure the safety and effectiveness of the medicines. Both of the refrigerators were storing temperature sensitive medicines. The temperatures recorded showed the medicines in one refrigerator were being stored at a lower temperature than they should be and medicines in the second fridge were being stored at a higher temperature than they should be. This meant the temperature sensitive medicines needed to be destroyed as they were not safe to use. We discussed the management of these to ensure people received medicines that would effectively treat their condition.

We looked at the records of two people who were administering some of their medicines independently. We found a risk assessment had been completed for one person to show they were able to do this safely, but no risk assessment had been completed for the other person. Systems were not in place to monitor these people and therefore the service could not be sure that these medicines were being administered as they were intended to be.

This was a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us they would take the necessary actions to address the concerns we had found with medicine management.

People told us they felt safe, one person told us, "Yes (feel safe). It's very much better than living on my own. Everything makes me feel safe, if you ask anything they try to sort it." Another said, "Yes (feel safe). I've spent most of my time in this room, keeping myself to myself… I haven't really thought about it, I just feel safe."

People said if they didn't feel safe and needed to talk with someone, they felt confident to approach the staff. One person told us, "Whoever's out here, one of the staff. There's always someone." Another said, "Any of the staff."

Staff knew they had a responsibility to manage risks and to keep people safe. One staff member told us, "I

think people are safe. We know what the risks are and there is guidance for us to follow." Other staff told us, "Some people have fall sensors (mats that alert staff when stepped on) because they are at high risk of falls. Having the sensors keeps them safer." And "I always make sure people have their calls bells so they can get our attention if they need us."

Staff shared information about people's changing needs at handover meetings at the beginning of each shift so they could ensure any risks or concerns could be monitored or followed up with healthcare professionals. One staff member told us, "We get told what's been happening, things like any falls any medicine changes so it is informative." Another told us, "Yes, it's useful, information is read out to us. It's good especially if I have been off for a few days."

People's needs had been assessed so that any risks associated with their care could be managed. Staff were able to tell us about some of these risks so they could manage people's care safely but when we reviewed some people's records to check how risks were managed, we could not be sure instructions were always followed. For example, one person had a risk assessment relating to swollen legs. There was an instruction for staff to check the person's legs daily, to apply a prescribed cream daily and to ensure the person had bed rest where they were to elevate their legs. We could not confirm from records, this always happened. The daily records made no reference to the person's legs being elevated. The "Topical Medicines Administration Record" for this person contained an instruction that stated "Apply to dry legs twice" with no further details of what to apply and when. When we checked the entries to see when prescribed creams had been applied, on some days the record was blank suggesting the cream had not been applied at all. This person also had a health condition which meant it was important their nail care was attended to regularly. Nail care records were blank for March, April and May 2017 and there were no references in the daily records we viewed to show this was being done.

For another person we checked how the risks associated with their nutrition were managed. They were required to have the amount they drank each day monitored to make sure they were drinking enough. The charts used to monitor this were not always fully completed to show how much fluid staff should aim to provide to the person each day. Where a 'target' amount had been indicated, we found that most of the time records showed they were not consuming this amount.

However, other risks such as those related to moving people safely were being managed. For example, one person at risk of falls had been assessed and a 'falls risk assessment' instructed staff to ensure the person was supported by two staff during transfers. Staff were also alerted to the fact the person may become confused and attempt to walk independently and to monitor the person to ensure this risk was managed. Falls were recorded in the accident and incident records demonstrating they were being monitored. A staff member described how they moved a person safely. The person was cared for in bed. They told us, "There are always two of us to hoist them to make sure they are safe. As they are tiny we use the small sling which is kept in their room (so they didn't fall out). It has their name on it." This information corresponded with what was written in the person's risk assessment so that all staff knew how to move the person safely.

Accidents and incidents were recorded each month and records showed they were reviewed by the provider's management team 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.

People had mixed views about there being enough staff available to support them. There had been occasions when agency staff had worked in the home on a regular basis to cover shifts but more recently their usage had reduced. One person commented, "In the day time, there are enough, but I don't really notice at night. I haven't needed them at night." Another commented, "Not enough on some occasions, they

seem to be run ragged at times." A relative told us, "Oh yes, they're very good. There's always somebody about."

The Provider Information Return forwarded to us prior to our visit told us, "We carry out a frequent review of staffing levels using the dependency tool to ensure staffing levels are appropriate to the need of the residents." We found improvements had been made to staffing arrangements since of our last visit.

Staff told us they managed to complete their care duties to ensure people's needs were met and they always made sure people were washed and cared for properly. However, they explained on occasions it was a challenge to get everything they needed to do during their shift completed including the records. One member told us, "It's a bit of a juggling act to get everything done." Another said, "Today is okay as we have a work experience person so they can make drinks for people so it frees us up a bit to do checks." One staff member told us, "Sometimes when it's busy we can struggle a bit but overall we can provide the care people want."

Staff aimed to ensure there were staff present in the lounge so they could make sure people were kept safe. The provider had recently increased the number of care staff from three to four during the day to help ensure people could be supported as required. We saw there were enough staff available to people and staff were in lounges except when they began to support people to the dining room. They did not rush people when providing care suggesting the increased staff numbers were having a positive effect.

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.

Staff were able to describe their understanding of abuse so they would know how to recognise any potential abuse and act on this. Comments included, "Anything that causes harm" and "Wrong medicines being given" and "Neglecting people or ignoring them if they ask for my help." 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). The Provider Information Return forwarded to us prior to our visit told us, "All colleagues are aware of the confidential whistleblowing line. Colleagues are encouraged to report any incident or suspected safeguarding quickly, openly and transparently." Staff confirmed they were confident to raise concerns if they witnessed poor practice so that action could be taken to keep people safe. One staff member told us there was a 'Speak up' policy they had been given with contact details of who they could speak with if they did not feel they could talk to the registered manager. They commented, "I have a duty to speak out if I see poor practice."

The provider had implemented training for staff in emergency procedures to minimise the impact of unexpected events such as a fire. Some staff were required to update their training but most had completed this as required. The fire procedure was on display in communal areas of the home which provided information for people and their visitors on what they should do in the event of a fire. Personal evacuation plans had been developed for people to assist emergency service staff in the event people would need to be evacuated.

Regular checks were carried out to ensure the building and equipment was safe for people. Checks included electrical checks and hot water checks. A maintenance person worked at the home to undertake general repairs and complete the checks.

Requires Improvement

Is the service effective?

Our findings

People felt the care provided at Victoria Park was effective in meeting people's needs and staff were suitably trained and knew how to support them. Comments included, "I get the impression looking at other people (staff) that they know what they're doing, but they haven't had to do anything for me." And, "Yes they know what they're on about." One person commented "Yes, the majority of them do" but went on to explain some of the agency staff who had worked at the home had not been effective in supporting their needs. We noted that agency staff usage had reduced in the home recently.

Staff told us they had received an induction to the home when they started to ensure they understood their roles and responsibilities. They told us they found this was sufficient to support them in their roles. One staff member told us, "Induction was good. I had a week of shadowing (working alongside more experienced staff) and training." Another told us, "I was shown around, had four days training and couple of days shadowing. It was enough."

The Provider Information Return received prior to our inspection told us the provider ensured training was linked to the Care Certificate. It stated, "Our mandatory training is done through a blend of e-learning and classroom/off line assignments and is aligned with the Care Certificate." To receive the Care Certificate staff have to demonstrate they have the skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support. Staff told us they received ongoing training so they could carry out their role effectively. Staff commented, "I think the training is good but I don't always get time to do the online learning" and "We watch videos, have discussions and fill in question sheets." One staff member told us how helpful they had found the training about working with people with dementia, they told us, "I leant about dementia. How people see the world which gave me an insight into the condition."

Training records showed most staff had completed all of their required training to help ensure they had the right skills and knowledge to provide effective care and support to people. However, we identified some gaps in training when we reviewed printed training records for five staff. There were two staff that had not completed the training within the timescale allocated. This training included food safety, safeguarding and medicines training. We had identified concerns during our inspection in relation to these areas. For example, staff who had completed training in medicines had not identified that some medicines were not being managed correctly. We also noted that staff did not always recognise symptoms of a health condition to ensure this was effectively managed. Two people had been admitted to hospital for treatment after complaining of symptoms associated with this condition. We identified a third person with this same health condition had not been given their medicines regularly to treat it which had resulted in a negative impact to their wellbeing. This was despite staff being told to monitor people with this condition. This suggested training linked to people's healthcare needs may need to be reviewed.

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 an assessment shows a person lacks mental capacity to take particular decisions, any made on their behalf must be in their best

interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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.

At our last visit we found the provider had not always sought advice and guidance in relation to assessing people's mental capacity where there was a doubt that a person had capacity to make a decision. This posed a risk people may not have been supported correctly under the principles of MCA.

During this visit we found improvements had been made. Staff knew that some people who lived at Victoria Park lacked capacity to make their own decisions. They told us they had completed training in MCA and understood their responsibility to act in people's best interests when it was identified they lacked capacity to make a specific decision. Staff commented, "MCA is about people's capacity to make decisions. It's the law" and "Some people can't consent to their care because of their dementia." One staff member explained how they knew people needed to be assessed if they lacked capacity and a decision needed to be made in their best interest with people involved in their care. They told us, "It's about choices, people have to be assessed if they can't make choices. The GP or social worker are involved."

People told us that staff asked them for consent before providing care. One person told us, "They tell me what they're going to do. They don't have to ask me, they wouldn't do it if they didn't have to. I mostly get on with them." Another said, "Yes (ask for consent) not always, but nearly always."

We saw staff asked people for their consent before they provided care to make sure they were in agreement to accept support. For example, one staff member asked, "Shall I help you move to a comfy armchair?" When the person responded, "No I can do it myself thank you" this decision was respected. Another staff member asked a person, "Shall I cut up your meat?" The person responded, "Yes please, I am struggling a bit" and the staff member assisted them.

Staff understood that if they placed restrictions on people's care and support this could amount to a deprivation of their liberty such as restricting people in being able to leave the building because it was not safe for them to do so. They knew that any restrictions needed to be in the person's best interest. Staff knew about people with a DoLS. One staff member told us, "[Person] can't go out on his own because he can't keep himself safe." Another staff member told us "[Person] has a DoLS because he can't consent to his care."

The registered manager had applied for a DoLS for some people who lived at the home, because they did not have the capacity to understand the risks associated with the restrictions to their liberty.

People were given choices about their daily care and how they spent their day. One person told us, "Me and my friend, we stay up till 12, we could sit there all night if we wanted."

People gave mixed feedback about the food provided. For example, positive comments included, "The food is good. You do sometimes get things you don't want but on the whole it's good." And "Brilliant, I've got no complaints whatsoever. They give you too much sometimes. They come round and ask if you want more." The negative responses included, "I don't like it so what they're doing for me is salad and it agrees with me." And "A sore point… The amount you get is not always adequate and I've got a small appetite." One person told us, "If anyone else asks me if I want a ham or cheese sandwich I will scream. All you get offered is a ham or cheese sandwich." We established this person had special dietary needs which restricted their choices

but the person did not feel staff always knew what they could eat to ensure they had a variety of meals. The cook knew about this person's needs and told us. "[Person] knows what they can and can't have. I would never stop them from eating what [Person] likes they know the consequences." Staff knew about what people food choices and were able to explain their likes and dislikes such as one person preferred brown bread sandwiches rather than white. This person told us, "Brown is always bought for me. I think it's only me that likes it." This demonstrated people preferences were taken into consideration.

At lunch time people chose where to have their meals and where they wanted to sit. Staff were supportive and observant of people who needed assistance such as those people who needed their food to be cut up. Where one person was sleepy and unresponsive, staff took the person into the lounge where the person was more responsive and they then assisted the person to eat. This showed that staff knew this different approach may encourage the person to eat.

People were offered a choice of drinks and we saw a staff member add a thickening agent to a drink for one person so they did not choke when drinking it. We noted the dining room was tight on space due to a number of people being supported to tables in wheelchairs, this issue had also been raised by relatives but this remained a problem if people wished to use that particular dining room. However, there were other dining facilities in the home that could be used. Once all were seated, staff asked people what they wanted to eat. The menu said the choices were "Chicken stuffed with spinach and mushrooms" or "Beef salad". The chicken option served was not as advertised on the menu. However, people were able to choose what they wanted. A pureed meal was served to one person and each part of their meal had been pureed separately so they could experience and enjoy the different flavours. People were offered hot and cold drinks which included sherry and wine and were asked if they wanted to wear clothes protectors. Some people were offered second helpings.

Where people were at risk of dehydration or malnutrition this was identified through the risk assessment process. Some people needed their food and fluid intake monitored by staff using a chart system. We looked at a selection of these records and they had not been completed consistently to demonstrate people had received sufficient nutritional intake to maintain their health. Accurate quantities of food had not being recorded and fluid targets and total consumption were also not recorded to ensure this was sufficient. When we asked a staff member about this they told us, "We haven't put the target on. Someone has forgotten. I will do it now." They went on to explain how the target was calculated so that staff would know what volume of drinks the person should be given.

People told us they were able to access a doctor if they needed one. One person told us, "Only if I request it. I slipped and hurt my leg. They got the doctor and he sent me to A and E." Another told us, "The doctor will come if I want him or her." A relative said that arrangements were made for their family member to see the doctor or other health professionals if needed and that staff kept them informed about this. They told us, "If anything is necessary, yes. She had the doctor out last week when she wasn't very well. They always let us know."

People's records showed that staff worked with health professionals to maintain people's health and wellbeing. Where changes in people's health were identified they were referred to the relevant healthcare professionals including their GP.

Requires Improvement

Is the service caring?

Our findings

We asked people if they felt staff had a caring attitude. Comments included, "Some do, some don't. A lot of them I haven't had any dealings with. They way I've seen them with others, they seem to be caring," and "Yes. They're just there if you need them and you can talk to them, even in the middle of the night. There's always somebody about. One person said, "They're alright. They work very hard. It's alright when they're friendly and we can have a laugh." A relative told us, "Yes, very much so," when asked if staff were caring.

Overall, during our inspection visit we saw staff had a kind and caring approach towards people. Staff regularly worked with the same people so they knew them well and understood how they wanted to be cared for. Staff bent down or sat down to speak with people to be respectful by being at their level. They whispered in people's ears to ensure their conversations were not overheard when they asked people if they needed to use the toilet. People were asked if they wanted the windows and doors open as it was warm in the communal lounge. People agreed and a staff member said, "If it gets cold give me a shout and I'll close it."

There were some staff that showed concern for people's well-being. One staff member told us "We are worried about [Person's] weight loss, we are all so fond of them, we hope they are not poorly." However there was one person who had a negative experience in the lounge. We observed during the morning, the person had spoken with a staff member to tell them they would need assistance to go to the "ladies" but "not yet." Later when the person asked a different member of staff to take them to the ladies, the staff member responded, "I will take you in a minute." The person persisted to ask and became unsettled. After the person had asked for a third time and the staff member's reply was "Just be patient" we intervened. It was established the staff member had misinterpreted that "the ladies" meant to join the other ladies who had moved upstairs and not the toilet. However, there was a second staff member in the lounge at the time that also ignored the person's plea and staff had not recognised the person was becoming anxious as a result of their request not being met.

We noted that one person had been asleep in the lounge for most of the morning. There had been no staff interaction and everyone had been given a drink except for this person. It was only when the area director came into the lounge and questioned this, the person was provided with a drink. People had been provided with teacakes but no plates or serviettes and the area director provided these to everyone and prompted staff to do this. However, when this was pointed out, staff said people had a plate and pointed to the saucer under the cups. There was a lack of understanding this was something different. We noted later when people were given biscuits no plate was used despite them being instructed to do this.

We saw staff encouraged people to be independent. They gave people encouragement when they were walking. They told one person "Nearly there, well done, you can do it." The person said, "I can do it, I will do it" which showed the encouragement was working as they wanted to walk independently. We noted when people were not feeling well, staff were sympathetic towards them. For example, during the morning when people were being assisted to the dining room, a staff member asked a person if they needed any help to walk with their frame. The person responded by saying they felt unwell and were asked, "Do you want to

stay here then in your chair." The person responded they did and staff respected this decision.

Overall, people felt that staff were respectful towards them. Staff referred to people by their preferred name, and maintained eye-to-eye contact when speaking with them. We saw examples of staff taking time with people when delivering care so they did not feel rushed such as when providing them with assistance to move from one area of the home to another.

We asked staff how they built relationships with people. One staff member told us, "Spending time with them, listening to them." Another said, "I love my job and love the residents we have good relationships as I go out of my way to get to know them." We asked staff what made them caring. One staff member told us, "I am gentle when I wash people and patient so they don't feel rushed." Another told us "Taking my time when helping [Person] to eat, chatting to them and making them laugh." One staff member told us they did shopping for some people in their own time.

Most people felt their privacy and dignity needs were met. They told us, "They even knock my door when they bring a cup of tea. There's no problem there. If they don't see you for a couple of hours, they come and knock the door to see that you're okay." And "You can please yourself what you do. Sometimes, you're not quite asleep and they come and open the door to see if you're alright. I think that's good. They would knock on the door." However, one person felt their privacy and dignity needs were not met. They told us, "It's not unusual for them to walk in while I'm sitting on the loo. They just stand there looking. That's the kind of thing I don't like. I shout if I'm on the toilet and I hear them coming but before I know it they're standing there looking at me!"

When we spoke with staff, they knew what they should do to maintain people's privacy and dignity. One staff member told us, "I knock doors before I enter, that's respectful." Another told us, "I know to cover people to protect their dignity."

During our visit we observed a relative and the registered manager having a private conversation in the reception area of the home about a person. The family member had not been directed to the registered manager's office so this conversation could be held privately. We raised this with the area director at the time so that action could be taken to ensure their privacy.

People were encouraged to maintain relationships important to them. People told us that visitors were welcome at any time. One person said their family members could visit "All day any day."

Staff told us that some people had received the support of advocates when they had no family members to support them. An advocate is a person who supports people to express their wishes and weigh up the options available to them, to help them to make a decision. One staff member told us, "Some people have had advocates in the past to help them make decisions." Another told us, "Advocates are available if people want them." This showed action was taken to ensure people had someone independent to support them when required."

Requires Improvement

Is the service responsive?

Our findings

During our last inspection we found the service was not consistently responsive to people's needs. There had been agency staff working at the home which had impacted on people's views because they were not as familiar with people's needs as the regular staff. Since our last visit, the provider had taken action to reduce the number and frequency of agency staff working at the home.

During this inspection, people told us they felt most of the time staff responded to their needs and maintained their independence. One person told us, "I've got so much control myself, if I said no, I didn't want to do something, I wouldn't have to do it."

A relative told us they were happy with the care their family member received and that staff were responsive to their family member's needs. They told us the "cook" made the person's favourite food which they "loved" and also put on a prayer channel for the person every day to support their cultural needs. They told us, [Person] has a mobile phone to call me whenever they want to. Staff charge it up for them," which showed they supported the person to maintain family contact which was important to them.

We saw staff were attentive to people's needs. For example, one person got upset when they spilt tea down their jumper. A staff member gave the person a hug which they responded to well. The person was asked if they wanted to change their jumper but refused. This decision was respected. Another person asked a staff member to change their bedding and this was promptly done. When one person said they were cold staff quickly bought them a blanket.

People gave mixed views about their experiences of having a bath or shower when they wanted. One person told us, "I'm going to ask them today. You get it the same day you ask. They might suggest a shower for their convenience but I say no. In the bath, the shower head isn't working properly so they can't rinse my hair properly, they rinse it with the bath water." Another told us, "I've sorted that out. I was most disappointed with the bath because there was so much metal work there was no room to sit. It wasn't a pleasure. I have a shower. I didn't get a shower till just before 12 today. I was waiting from 9.30am. They started and then left me in the middle of getting ready. I was ready to explode." This showed action was required to ensure people had a more positive experience when they wanted a bath or shower.

People's care needs were assessed and relatives had been involved in the initial assessments to plan care. This helped to ensure people's needs could be met before an agreement was made for them to live at the home. Some people knew they had a care plan demonstrating they were involved in planning their ongoing care. One person told us, "I believe I've seen my care plan just recently." Another told us they had been involved in some meetings with their family member about their care plan.

Care plans we looked at contained some personalised information, for example, in one care plan it stated the person, "Always likes to wear slipper socks as she gets cold feet." Staff knew this and we saw the person was wearing slipper socks. People's life histories documented information such as, their fondest memories and their fears and phobias. However, this information was not always transferred into care plans. For

example, one life history stated the person enjoyed the warm weather but did not like direct sunlight. This information was not in their care plan and staff did not know this. Recent records showed the person had spent time outside and had been sun burnt. We asked staff about this and they told us they were not aware this had happened. They told us they did not have any sunscreen or hats to give to people if they wanted to go outdoors in sunny weather. One staff member said, "Gosh, I will speak with the senior, I don't want people to get burnt."

We asked people if they were supported with their hobbies and interests and comments suggested this was an area that could be improved for some, although there were some that enjoyed them. One person told us, "On a nice day, you can go out onto the roof (roof patio area). You can go and play bingo." Another told us, "No (not supported), I just get on with it. There is a girl. She's doing baking but that is probably just one person going with her. I did bingo. That was alright. She suggested penfriends but I didn't think it was a good idea, how it was going to work. Nothing much happens that's interesting or time consuming. It seems to suit most people but it's not enough for me. It's not ideal." One person told us they had previously been a carpenter and they had helped the handyman put some outdoor seating together which they had enjoyed.

We asked the activity organiser how they ensured people's interests and preferences for hobbies were met. They told us, "When people move in I go and meet them. I find out what they like doing to offer activities to meet their needs. Some people enjoy the outdoors but we haven't really got a garden area." They went on to explain how an indoor garden area had been created with artificial turf, a light up sensory tree and garden seating. They told us, "Some people really enjoy sitting there. We are purchasing some live plants and have purchased a CD which has bird sounds." They told us that outside entertainers visited the home about once a month and there was an "exercise man" who also visited. They recognised that some people stayed in their bedrooms so they spent time with people in their rooms each Tuesday if they didn't want to join in group activity sessions. It was clear the activity organiser wanted to ensure that everyone had something of interest they could participate in. They told us how they aimed to continually improve activities in the home. They said, "I visited two other homes to look at how activities were provided to get some ideas. For example, some people now have pen pals at [Name of another home]. They write letters to each other. Each month activities coordinators have a teleconference to share ideas."

Although people's care plan records were not always clear about hobbies, interests and preferences, overall, staff knew about people's needs and how to support them. People were offered daily choices such as food and drinks. Staff were seen to ask "Do you want tea or coffee? Anyone fancy a bit of cake?" People were given time to answer questions that staff asked them. Staff told us how they offered people choices when providing personal care. One staff member told us, "I show [Person] items of their clothing. They can point to the clothes they want to wear. Other people make their choices by nodding to say yes or shaking their head to say no."

The Provider Information Return told us, "We encourage community links here at Victoria Park. We have Holy Communion and we work with colleagues and schools for student placements." We were able to confirm this information during our visit. Staff told us about how they maintained one person's cultural needs. They told us how it was important for the person to wear a headscarf and we saw this being worn. We asked if there was anything else they did to support people's cultural needs. A staff member told us, "Different meals are available, for example, curries which some people enjoy. We celebrate Diwali, Easter and Christmas." We were also told that one person liked to pray before meals and others were encouraged to join in if they wished.

One person was described in their care records as being "very sociable" and liked to spend time in the lounge so they could take part in activities. We saw this happened. During the day a large group of people

participated in a parachute game in the lounge on the ground floor where people at random were asked for information about their names and ages to share with other members of the group. Some people didn't want to share their age and the staff member who was undertaking the activity respected this. The staff member joked with people about being 21 when they didn't want to share their age which made everyone in the group laugh including those who didn't wish to share their age. In the upstairs lounge during the morning a similar parachute activity took place. The activities co-ordinator, a staff member and five people were all raising and lowering the parachute together following the instructions given by the activities co-ordinator. We heard laughter and saw people were keen to be involved in the activity. One person commented, "It's a good bit of fun that is, very good."

Once the parachute activity was over on the ground floor everyone was asked if they wanted a "hot chocolate with "squirty cream" most people said they would and this was provided which people seemed to enjoy. Staff held a conversation with one person about the parachute and the person said they would like to use it as they had used parachutes when they had been in the Army. This showed staff took opportunities to engage with people on a one to one basis when they could.

Staff had recognised the weather was warm and told people after lunch they would take them out onto the balcony "to get some sun" if they wanted to. We later saw people sitting on the balcony showing staff had done what they said they would do.

We asked staff how people could feel reassured their views were listened to. Staff told us, "People have meetings which they can attend if they want to." And "The chef asks people what they think of the food." Staff told us that people were also asked to nominate a 'care worker of the month'." This showed there were systems in place to involve people in decisions that impacted on their care.

We noted that day and date signage was in place on both floors of the home so that people could see this information. The date, day, season and weather were correctly displayed.

People told us they would feel comfortable to raise any concerns with staff if they needed to. One person told us, "If I had to, yes I would (raise a concern). If there's anything going on, I'll put my two penny worth in." Another told us, "I'd tell them. I don't put up with any nonsense."

There was a system and procedure in place to record and respond to any concerns or complaints about the service. However, it was not immediately clear that the poster displayed in the home contained information about how to make a complaint as it was not referred to as a "complaint procedure". We noted that the information on this poster did not include all options to ensure people knew who they could escalate their concerns to if they were not happy with how the home managed their concerns.

Staff understood their responsibility to ensure any complaints they were made aware of were reported to the registered manager and to take action to address them if it was something simple they could resolve. One staff member told us, "If someone was unhappy I would tell the manager. They would go and talk to them to see what was wrong." Another staff member told us, "I would listen to the person and try and help them resolve their complaint."

Complaints records were kept when concerns were raised. However, responses and outcomes of complaints were not available within the records. The area director took action to locate the responses made to people and we saw from these that people's complaints had been acted upon and taken seriously. Following our inspection visit to the home, the registered manager forwarded to us information they planned to use to improve the complaints procedure in the home.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection visit we found processes and systems to identify risks related to the health, safety and welfare of people living in the home were not sufficient to ensure people's needs were met safely and effectively. There had been an inconsistency of leadership at the home which had impacted on the quality of care people received. There was no registered manager in post.

Following our last inspection the provider implemented an action plan to make the necessary improvements. As part of this action plan the provider said they would review all care plans in the home. We were told during this inspection, this had been done. We were also told quality assurance audits would be completed and analysed. We found this to be the case. Whilst improvements had been made within the service, we found there was a continued breach of the regulations in regards to medicine management. Systems and processes implemented had not been effective to ensure the ongoing safe management of medicines.

We identified that some of the medicine errors made had been by agency staff who were not fully familiar with people and their medicines. There was no effective process to ensure agency staff had 'at a glance' information about people's needs to ensure they were met safely and effectively. One person told us, "I don't like it when agency staff come in and know beggar all. Many times I have to tell them what to do. I've told two to get out. They haven't got a clue. One just gave the bed pan to me!" We spoke with a member of agency staff working in the home and they told us the only information they were provided with about people was a "handover" sheet which staff completed at the end of their shift. This stated the condition of people and those people who needed two staff to assist them. They felt this information was not sufficiently detailed to support them in getting to know about people and their needs. They told us they had access to the care files if they needed. They told us they usually asked staff for information when they were told to assist someone so they would know how to do this safely. We discussed information available to agency staff with the management team so consideration could be given to how this could be improved.

We found that records were not always clear or sufficiently detailed to ensure risks were managed consistently. Information about specific care needs was not always easy to find in care plans. This was partly due to information not being cross referenced to ensure staff could locate specific information easily. For example, a "Diet Notification" and "Eating and drinking" care plan for a person on a special diet did not contain information about what they could eat. This information was listed on a separate sheet at the back of the care file but staff were not signposted to this. The care plan records stated "[Person] needs supplements to support their weight, GP will need to be notified…." When we looked at the care plan review information, it was not evident this had been followed up. When we checked the medicine records they did not show the person had been prescribed any supplements.

Another person had a "Skin integrity" care plan that showed the person had a healing wound but no information about how the wound was to be managed. A skin condition this person had was not mentioned in this care plan. There was no instruction for staff to reference a "wound" care plan that indicated district nurses were treating the wound and staff were to alert the nurses if there was a problem with the dressings.

Another person had a body map that showed they had a sore on their toe but "not a pressure sore". However, the "skin integrity" care plan stated this was a pressure sore which was conflicting.

Although nutritional records were maintained to monitor the amount of food people ate and drank, it was not evident audit processes were effective in checking people's nutritional needs were being met. We identified one person was not consuming the amount of drinks that they should.

People and their relatives generally felt the home was well-led. We asked people what the atmosphere in the home was like. Comments included, "It's alright. There's people you can't make contact with but I say 'give me a smile' and they do," and "If they (staff) weren't so overworked they'd be a lot happier. There are new staff all the time and it's hard work." One person told us they could have a "laugh and a joke" with the staff and said "Everybody is brilliant here, you can ask them something and they'll sort it out."

We asked people what was good about living at Victoria Park. One person told us, "You know that there's someone there to do what you want and look after you. Since I've been here I've put on a bit of weight. Your meals are done for you, at home, I couldn't be bothered. You've got company. I find the place good." Another told us, "I have no worries. I'm looked after from every direction. What more can you want?"

Staff told us they felt the care provided at the home was good. One told us, "I think the care is good and people are happy. Now we use less agency its better as staff know people." Another told us, "Overall it's good, always room for improvement."

Since the last inspection the provider had appointed a new manager. They were appointed in September 2016 and had since registered with us. We asked people about the new registered manager. One person told us, "I've seen her once or twice. She is not always around … I see the deputy manager more." Another told us, "Yes, she's out and about but mainly in the office. You can knock the door and go in. She's always available."

The registered manager had a good understanding of their role. They told us about plans to have a manager's surgery once a month so they could share information on good practice to help drive improvement within the home. They told us there were daily "flash" meetings where staff shared with them any information they felt they needed to know as well as any issues of concern. This was to help effective communication across the home. For example, at one meeting, staff had reported that a person's dressing needed attention so ensure the wound was not compromised by the risk of infection. The registered manager had reported this to the district nurse and they were due to visit the person. `

Staff told us they felt supported by the registered manager. They said they had regular opportunities to get together at team meetings to discuss the service and any issues or good practice. We asked staff how they knew what was expected of them in their role. One staff member told us, "I get training and I was given a job description which made things clear." Another told us, "I know I need to report to the senior, it was explained who my manager was and the structure of the management team." Staff knew they were required to work in accordance with the provider's policies and procedures. One staff member told us, "We have team meetings, we can contribute but a lot of decisions are made at corporate level which can be frustrating. We are told it's company policy." Another told us, "We are a bit restricted as polices are quite strict but if I thought something could be improved, I am sure the manager would listen to me." Staff told us they had raised an issued about there not being enough staff and management had taken action to increase staffing levels which made staff feel listened to. One staff member told us a suggestion about having some new pictures in the home had also resulted in new pictures being purchased to "brighten the home up a bit".

Staff spoke positively of the registered manager and the management team. One staff member told us, "I get on well with all of the managers. They are approachable." Other comments from staff included, "Overall, yes. I think she (registered manager) is doing a good job. I have seen positive changes and I think she manages us all well" and "Since she had been here things have been a bit better but her hands are tied by corporate policies."

Staff said they had opportunities to learn about any poor practice at team meetings. One staff member told us, "I know safeguarding outcomes are discussed in team meetings so we can reflect on what happened so it doesn't happen again."

The management team encouraged feedback from people, their relatives, visitors and staff. This included people and their relatives being asked to complete an annual quality questionnaire. We saw the results of surveys had been analysed. However, it was not always clear action had been taken to address areas identified for improvement. Results of a recent questionnaire showed positive results in relation to cleanliness, safety and ambience of the home. Areas where some improvements were identified were in relation to people's dining experience and care staff being "well trained" in their roles.

A relative had commented that recently they were "often" left outside waiting to gain entrance to the home. We noted the main door to the home was kept locked and when a person arrived to make a delivery, the agency staff member did not know the code. They twice had to ask staff for the code and the person was kept waiting at the door. This suggested entry arrangements may need to be reviewed to ensure people were not kept waiting unnecessarily.

People and relatives were given the opportunity to attend meetings within the home and most people knew they took place but chose not to attend. One person told us, "I've been told I can go up and join in." The registered manager told us there were plans for these meetings to be held monthly although this depended on whether people and their relatives chose to attend. They advised they had attempted to change the timing of these to accommodate relatives who may not be available during the day.

The registered manager told us the provider required them to undertake quality audits and checks so they could monitor the quality and safety of the services provided to people. It was evident from our inspection of the home that ongoing checks were required to ensure the necessary areas for improvement were identified and acted upon. The area director regularly visited the home to provide support and ensure the registered manager and staff worked in accordance with the provider's policies and procedures.

We saw there was a comments book that people and visitors could complete. Comments recorded were positive including, "'Very impressed with the care dad receives" and "Highly impressed with the care my dad [Name] receives."

We saw there was a maintenance person working in the home to ensure the health and safety of the environment was maintained. People spoke positively about them. One person told us, "They've got a handyman who does little jobs." Another told us, "They've got a very good handyman."

The provider had, submitted notifications of incidents and events involving the service to the Care Quality Commission as required. This was so we could monitor any trends or concerns and be assured the provider had appropriately acted on them. The ratings from our previous inspection visit were displayed in the home.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not consistently managed or administered safely as prescribed and staff did not always follow good practice.

The enforcement action we took:

Warning Notice