

Mrs Saima Raja







# Victoria Lodge Residential Care Home

## Inspection report

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Date of inspection visit: 26 February & 12 March 2015  
Date of publication: 22/04/2015

### 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	

### Overall summary

This inspection took place on 26 February and 12 March 2015 and was unannounced. The home was previously inspected in April 2014 where they were found to have breached one of the Regulations we looked at. This was regulation 10 assessing and monitoring the quality of

service provision, Health and social Care Act 2008. We carried out a follow up in September 2014 to check that the service had made the necessary improvements to address this breach.

Victoria Lodge Residential Home is a care home providing accommodation for older people who require personal

# Summary of findings

care. It also accommodates people who have a diagnosis of dementia. It can accommodate up to 24 people over two floors. The floors are accessed by a passenger lift. The service is situated in Edenthorpe near Doncaster.

The home has a registered manager. '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.

People using the service and the relatives we spoke with were generally satisfied with the service. However, we found that people's health and welfare needs were not always met.

People we spoke with said they were very happy with the care provided and that the care staff worked hard and were very good. However, we found people's view did not always reflect what we found. The care plans we looked at identified people's needs. We saw these had been reviewed however the reviews had not taken account of people's changing needs so their care plans did not fully reflect the care they required. We also found Individual risks had been assessed and identified as part of the support and care planning process. However these had not always been followed putting people at risk of harm.

People were not always protected from the risks of abuse. We found staff and the registered manager had not responded to allegations of abuse correctly.

The registered manager had an understanding of The Mental Capacity Act 2005 (MCA), which includes decisions about depriving people of their liberty. We found most staff we spoke with were knowledgeable on the requirements of this legislation and the registered

manager had already assessed people who accessed the services to determine if an application was required. The manager had sought advice from the local authority to determine when an application would be required. One person living at the service was subject to a DoLS and all the required measures were in place. However best interest's decision tools had not always been used to help make decisions for people who did not have the capacity to make themselves.

The manager had monitored the quality of the service, however the monitoring did not identify issues we had identified during our inspection. We found the audits were a tick box exercise and were not effective as they had not always identified where improvements were required to be made.

There were robust recruitment procedures in place, however these had not always been followed and we found some documentation missing at the first day of our inspection. When we visited on the second day the registered manager had ensured all documentation was available in staff recruitment files. Staff had received formal supervision and we saw they received an annual appraisal, However, these were not up to date.

The manager told us they had received no formal complaints since our last inspection, but was aware of how to respond if required. However people we spoke with told us they had raised concerns, the registered manager had eventually dealt with them, but these were not recorded.

We found four breaches 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.

# 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?

The service was not always safe.

Medicines were stored and administered safely. People received medication as prescribed.

We found staff and the registered manager had not responded to allegations of abuse correctly.

Individual risks had been assessed and identified as part of the support and care planning process. However these had not always been followed.

There were enough skilled and experienced staff to meet people's care needs. We saw when people needed support or assistance from staff there was always a member of staff available to give this support. However people told us there were not enough staff to provide activities or stimulation.

**Requires Improvement**



### Is the service effective?

The service was not effective.

Care plans identified people's needs, however they were not effective as they were not always followed.

Mental capacity assessments had taken place in line with The Mental Capacity Act 2005. However best interest's decision tools had not always been used to help make decisions for people who did not have the capacity to make themselves.

The food we saw was well presented and appetising. However, we found there was lack of choice available and people told us they had raised this with the registered manager but it had not been addressed.

The environment was being improved to ensure a well maintained home and standards of cleanliness were continuing to be improved. However, we found best practice guidance was not followed in regard to the environment for people living with dementia. .

**Requires Improvement**



### Is the service caring?

The service was not always caring

People told us they were happy with the care and support they received and their needs had been met. It was clear from our observations and from speaking with staff they had a good understanding of people's care and support needs and knew people well.

Relatives we spoke with told us the service was good and that staff were kind, considerate and respected people.

**Requires Improvement**



# Summary of findings

We did not see evidence that people had been involved in making decisions about their care or that staff took account of their individual needs and preferences. We did not always see staff offer people choices and choices or preferences were not documented in people's plans of care.

We saw people's privacy and dignity was respected by staff and staff were able to give examples of how they achieved this.

## Is the service responsive?

The service was not always responsive

People's health, care and support needs were assessed and reviewed. However, we found the support plans did not always reflect the person's changing needs. We found staff were knowledgeable on people's needs however these were not always documented or up to date in their plans of care.

The manager told us there was a comprehensive complaints' policy, this was explained to everyone who received a service. However we found this had not been followed.

There were residents and relative meeting to ensure good communication and sharing of information. This also gave the opportunity for people using the service and their relatives to raise any issues.

**Requires Improvement**



## Is the service well-led?

The service was not always well-led.

There was a registered manager in post.

There were systems for monitoring the quality of the service. However these systems were not effective as they had not identified where improvements were required or any action to address issues identified.

Accidents and incidents were recorded however, we found no evidence these were monitored by the registered manager or the provider to ensure any triggers or trends were identified.

Regular staff meetings were held to ensure good communication of any changes or new systems; they also gave staff opportunity to raise any issues.

**Requires Improvement**



# Victoria Lodge Residential 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 checked 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 26 February and 12 March 2015 and was unannounced. The inspection team was made up of two adult social care inspectors and infection prevention and control nurse specialist.

Before our inspection we reviewed all the information we held about the service. The provider had not completed a provider information return (PIR) as we had not requested one. This was because this inspection was bought forward due to concerns identified by the local authority and concerns raised with us. This is a document that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

We spoke with the local authority, commissioners, safeguarding and Doncaster Clonal Commissioning Group (CCG).

At the time of our inspection there were 20 people living in the home. The service consisted of two floors accessed by a passenger lift. The service provided care to people who were living with dementia.

As part of this inspection we undertook a Short Observation Framework for Inspection (SOFI) SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spent some time observing care in the lounge and dining room to help us understand the experience of people who used the service. We looked at all other areas of the home including some people's bedrooms, communal bathrooms and lounge areas. We looked at documents and records that related to people's care. We looked at three people's support plans. We also spoke with nine people who used the service and four relatives.

During our inspection we spoke with six members of care staff, the deputy manager and the registered manager. On the second day of our inspection we spoke with the provider who was at the home. We also looked at records relating to staff, medicines management and the management of the service.

# Is the service safe?

## Our findings

People who used the service said they felt safe living at Victoria Lodge. One person said, “I like it here the staff are lovely, they really look after me.” Another person told us, “I’m well looked after. I have nothing to grumble about.”

However, one person said, “Some [staff] are nicer than others” and another person said some staff rushed them.

The provider had safeguarding policies and procedures in place to guide practice. Staff we spoke with were aware of procedures to follow. However we found the systems were not effective in practice. There had been a large amount of safeguarding referrals. The information we received from the local authority safeguarding team showed since June 2014 there had been 16 referrals, although five of these related to the same incident. Some of these were still under investigation at the time of our inspection. When we discussed this with the registered manager they were not aware of this number and therefore had no oversight of referrals made.

A health care professional we spoke with who had investigated a safeguarding concern told us the allegation had been substantiated as neglect. They said they had recommended that staff on duty at the time of the incident received supervision to address the issues highlighted and evidence they understood what went wrong, why it went wrong and actions to take to prevent it occurring again. We found no evidence this had taken place, the registered manager said this was because they had not been given any feedback. An allegation the registered manager told us they had investigated was found to be unsubstantiated. However, there were no records relating to this safeguarding concern being investigated by the registered manager or the outcome. Discussions with the registered manager ascertained staff had been questioned, but no statements had been taken and there was no documentation of interviews or supervision in relation to issues raised. We found records in relation to safeguarding were poor.

The provider who was at the service on the second day of our visit acknowledged that records were insufficient and work was required to improve these. The lack of evidence to show what action had been taken meant people could be put at risk of harm as staff were not learning from incidents.

We looked at training records with regard to the protection of vulnerable adults and we found staff had received safeguarding of vulnerable adults training. However, we considered this had not been effective overall as procedures had not always been followed in relation to responding appropriately to allegations of abuse.

Before our inspection, we asked the local authority commissioners for their opinion of the service. They told us they had some concerns and were regularly monitoring the service. They said there had been a large number of safeguarding referrals and that the registered manager was not learning lessons from incidents.

This was in breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that medicines were managed and stored safely. We reviewed four people’s medication administration records (MAR) and observed part of the lunchtime administration of medicines. We observed a senior care worker give medicines to five people. We saw that they provided a drink for each person and were patient and gently when encouraging people to take their medicines. The senior care worker told us no one was given their medication covertly. This means it is given hidden in food or drink.

The home used a monitored dosage system. This meant that tablets were dispensed by the pharmacy in separate 28 day, ‘bubble’ packs. Each of the medicine records we saw included information about any allergies the person had, how they preferred to take their medicines and photographic identification. However, some of these needed to be improved and updated. For instance, not everyone’s record referred to them in the correct gender. The MAR chart we saw for one person showed they refused their medication on a regular basis. However, their written information said they were compliant and took their medication without difficulty. As required (PRN) prescriptions such as those for pain did not include the details of how people expressed pain. This is particularly important for people who relied on non-verbal communication.

The medication policy referred to medicines prescribed for ‘as and when required’ [PRN] but no protocols were in

## Is the service safe?

place for staff to follow. At the time of our visit no one was on PRN medicines and the registered manager agreed to update the policy and produce protocols to use if a person was prescribed this medication.

The room medicines were stored in had no hand washing facilities. The senior care worker showed us a nearby bathroom with a wash hand basin that staff used. The room and the medication fridge were within acceptable temperature ranges. There were separate locked, wall mounted steel cabinets for Controlled Drugs (CDs) and a separate record of CD was kept at the home.

There was an effective system of ordering medication This ensured the correct medicines were always available for people. Medicines that were no longer required were listed and disposed of appropriately. There was no overstocking of medicines or supplements. Information about medicines was available along with a copy of the medication policy. The senior care worker we spoke with had received medication training and they confirmed they had received updates.

With regard to the number of staff on duty, most people who used the service and relatives we spoke with said there were sufficient staff on duty to meet people's care needs. The registered manager showed us the staff duty rotas and explained how staff were allocated on each shift. Staffing levels were determined by the dependency levels of people who used the service. We saw there was enough care staff to meet the needs of people. Visiting health care

professionals we spoke with told us when they visited they always felt there was enough staff on duty, one visiting professional said, "I have visited at night and always found staff quick to open the door and people's needs being met."

We found the recruitment procedures ensured the required employment checks were undertaken. The registered manager told us that staff did not commence working with people who used the service until references had been received and they had obtained clearance to work from the Disclosure and Barring Service (DBS). The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. However, we found some information required was not in the files we checked. For example some references and working eligibility of staff. When we visited on the second day the registered manager had ensured all documentation was available in staff recruitment files.

As part of this inspection we looked at infection control and visited with an infection prevention and control nurse specialist. This was because they had previously visited the service and found improvements were required. At this visit they found many issues had been addressed in particular the cleanliness of the service. The registered manager told us the improvements would continue to ensure compliance with the actions identified by the infection control nurse. For example the bathroom would be decommissioned to provide a dedicated hairdressers and activity room for people to use.



# Is the service effective?

## Our findings

People who used the service and their visitors we spoke with all told us should a GP or other health care professional be required, a visit would be requested by staff. Relatives told us that if their family member had a fall or some other untoward occurrence, staff from the home telephoned them immediately.

Staff we spoke with were knowledgeable on people's needs and our observation showed they were able to meet people's needs. For example staff knew which people were at risk of falls and the action required to reduce this risk.

However, we were concerned that some people were wearing ill-fitting footwear and this may have put them at risk of falls. For instance one person was wearing a pair of shoes which were too big for them, with no socks and another person was wearing slippers which were very trodden down at the back. We saw two other people whose feet were swollen, and they wore shoes which looked very tight. We discussed this with the registered manager on the first day of the inspection. The registered manager had addressed this at our second day. Some people who could make choices still wore ill-fitting footwear but they had been made aware of the risks. This needed to be documented in their care plans.

We spent time in the lounge before lunch observing. We saw that staff chatted with some people and asked if they needed anything. However, there were long periods when some people were left without any interaction or stimulation. For instance, three people slept in chairs in one corner of the large lounge and were only approached by staff when it was lunchtime. One staff member advised us not to wake one person as they would, "Go mad." Another person appeared disorientated when woken. However, the staff continued to support other people to the dining room and did not stay to offer any explanation or reassurance.

We asked six people who used the service what they thought of the food in the home. Most people told us the food was good, although there was little choice. We were told the teatime meal was usually a choice of sandwiches, but this was very repetitive and there was rarely a choice of

a hot meal. One person told us when they moved in there was one choice at lunchtimes, and it had taken a long time to get a choice of food they liked, although things had improved in recent weeks.

On the first day of the inspection we sat and chatted with people during lunchtime. The atmosphere was quiet and relaxed and the tables were nicely set. However, when it came to serving the meals, they had been plated up in the kitchen and the staff who served them did not explain what they were serving to people. There was a menu board in the dining area, but nothing was written on it. We were told by staff that people had been asked what meal they wanted the day before, and they had been given the choice of sausage and mash or liver and onions. However we asked six people what was on the menu and no one was able to tell therefore people were not aware of the choices available.

Most people were served sausage with several different vegetables, mashed potatoes and gravy. One person's gravy was provided in a jug, but other people were not offered this option. Again, we saw one choice offered for dessert, although everyone we spoke with said they had enjoyed the sponge pudding and custard. Some people had their food pureed, due to their specific needs. Cold drinks were served at lunch, without people being given any choices. One staff member told us they knew people well, so they knew what they liked. However, staff did not remind people of their choice, tell people what they were serving or check if anyone had changed their minds.

Throughout the day, everyone who used the service was given hot or cold drinks in coloured plastic cups. During the meal no one was provided with aids or adaptations to help preserve their dignity or independence, such as plate guards. For instance, we saw that one person struggled to get their food onto their fork as it was pushed over to the side of their plate. They eventually expressed their exasperation and gave up trying.

After most people had finished their meal and had left the dining area, one staff member supported a person who needed one to one support to eat. They did this with quiet patience and at the person's pace. However, they also did this largely without speaking to the person.



## Is the service effective?

We also saw food was served on white plates. Best practice guidance, for example the 'EHE Environmental Assessment Tool' from Kings fund 2014, suggests that food and drinks should be presented on coloured plates so that it is appears more appealing to people living with dementia.

The registered manager had not taken into consideration the environment for people living with dementia. However, this was something the provider told us they were looking into so they could improve the environment to ensure it was more conducive for people living with dementia. For example, they said they would look at latest best practice guidance and consider painting bedroom and bathroom doors different colours so people were able to differentiate between them.

Staff said they had received training that had helped them to understand their role and responsibilities. We looked at training records which showed staff had completed a range of training sessions. The training record we saw showed staff were up to date with the mandatory training required by the provider. We saw evidence staff one to one supervision meetings with their manager had taken place and all staff had received an annual appraisal of their work performance. However, the providers policies in regard to supervision had not been followed. The policy stated staff should have received a supervision session every two months but this had not occurred. The staff told us they did feel supported and could talk to the registered manger if they wanted. The registered manager told us they had been short staffed so had been struggling to keep on top of supervisions. They also told us they were looking to employ a deputy manager who would work some supernumerary hours to ensure they had support to make sure staff were adequately supervised and apprised of the work they performed.

The registered manager told us they were in the process of sending staff on Mental Capacity Act and Deprivation of Liberty Safeguards training. The Mental Capacity Act 2005

(MCA) is legislation designed to protect people who are unable to make decisions for themselves. It also ensures that where people lack capacity to make decisions these are made formally to ensure they are in people's best interests. Staff told us they had enrolled on a distance learning course for mental capacity. We found that formal best interest decisions were not documented or completed. For example one person who lacked capacity to understand the need to take their medication, on occasions was given medication covertly; this is when medicine is hidden in food or drink. We found no best interest decision had been undertaken in line with the MCA. The best interest decision is used to help make decisions for people who did not have the capacity to make themselves. The registered manager acknowledged that these needed to be in place and told us this would be addressed.

The Mental Capacity Act 2005 includes decisions about depriving people of their liberty so that if a person lacks capacity they get the care and treatment they need where there is no less restrictive way of achieving this. The Mental Capacity Act Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to do so. As Victoria Lodge is registered as a care home, CQC is required by law to monitor the operation of the DoLS, and to report on what we find.

Staff we spoke with were not all able to describe to us what MCA and DoLS was, but did tell us they were booked on training to cover this. Staff that had been on the training were aware of the requirements. The registered manager was aware of the new DoLS guidance and was reviewing people who used the service to ensure new guidance was being followed. There was also a DoLS authorised for one person living at Victoria Lodge. The registered manager had applied for this to ensure the persons safety, the person was under continuous supervision and control to ensure they did not get out of the building.

# Is the service caring?

## Our findings

Most of the people we spoke with described most staff as kind and caring. One person said two named staff and the registered manager were, “Lovely and really look after me.” Another told us, “I’m well looked after. I have nothing to grumble about.” However, one person said, “Some are nicer than others” and another person said some staff rushed them.

We spoke with relatives who said, “The staff are good, they always let me know if my relative has been unwell.”

We observed some positive interactions with people and staff talking and laughing. Most people who used the service and their relatives we spoke with said that the staff were “Good.”

Most care workers we observed always asked people if it was alright to assist with care needs before they did anything. For example, we saw staff ask people before they helped with their meal and we also observed staff knock on people’s bedroom doors before entering. Staff also knew what they were doing to meet people’s needs at a basic level and treated them with respect and patience. However, we observed some staff not asking people their choice, not giving time for people to respond and did not listen to them. This was discussed with the registered manager and provider who agreed to look into this to ensure all staff respected people’s choices and decisions and gave time for people to be able to make decisions.

We looked at individual’s care files to see if they were individualised, we found they did not always reflect people’s choices, wishes or decisions and did not show involvement of the person. There were ‘day in the life’ information and their likes and dislikes included in the care files but these were not completed. The registered manager told us they would review the plans of care to ensure these were updated to reflect this.

Most staff we spoke with were thoughtful about people’s feelings and wellbeing. Staff gave good examples of how they were respectful and maintained people’s dignity. For example, staff spoke quietly when asking people if they wanted to use the bathroom. However on the first day of our inspection we found two people shared a bedroom where there was no privacy screens provided, and both people lacked the capacity to be able to make a decision to share a room. We discussed this with the registered manager who agreed to review the arrangements. At the second day of our inspection the registered manager had liaised with families and provided separate rooms for the two people. The registered manager agreed this would not be used as a double room in the future as it was too small and they would always struggle to provide privacy.

We asked the manager if the service had dignity champions to ensure people were respected and had their rights and wishes considered. They told us there were champions but more work was required and some further training as they felt staff did not fully understand the role.

People who used the service and relatives told us there were activities but they were not often enough and there was lack of stimulation. Staff told us they tried to organise activities but depending on how busy they were this was not always possible. The registered manager told us they did not have an activities coordinator but were in the process of recruiting one.

We saw people had chosen what they wanted to bring into the home to furnish their bedrooms. They had brought their ornaments and photographs of family and friends or other pictures for their walls. This personalised their space and supported people to orientate themselves.

# Is the service responsive?

## Our findings

Family members said they were welcome at the home at any time during the day or evening. Relatives we spoke with said they were always made welcome.

People who used the service and their relative's told us there were not enough activities or stimulation for people. Relative's said people using the service mostly watched television. Five of the seven people we spoke with regarding activities told us there were rarely any activities available. Four people told us they were not supported with any of the hobbies or interests they had before they moved into the home. There was some people's art work displayed in the dining room, however, we saw no scheduled activities taking place. Staff occasionally spent time with people individually. For instance, one staff member sat and read a letter to one person. On the second day of our inspection the registered manager told us activities were provided by a care worker. The care worker told us they were helping out until an activities coordinator was recruited. They were working when they were able to do additional hours. At the time of our visit they had organised a pamper session, including hand massage and painting people's nails. The people who were taking part were enjoying the activity.

Some people told us they preferred to spend their time in the smaller lounge, talking, listening to the radio and reading their newspapers.

We looked at three people's plans of care and found each person's care plan outlined areas where they needed support and gave instructions of how to support the person. However, we found they were not always followed so people's needs were not always met. We saw care needs were reviewed, but each entry stated, 'care need remains' but staff had not detailed the changes in the person's care. The registered manager acknowledged the reviews were not identifying people's changing needs.

One person's care plan stated they were at risk of falls and had a mobility care plan in place. This had been reviewed in January and February 2015 and it stated the care plan remains the same. The accident and body map records showed this person had sustained injuries from falls on

three occasions in this period. There was no reference to these falls in the care plan review. The lack of up to date assessment and care planned to reduce this risk put the person at risk of further falls.

Another person's care plan stated they should be weighed weekly to monitor their weight as they were at risk of poor nutritional intake. The care plan review on 19 January 2015 said 'remains the same', yet the records showed the person had been gradually losing weight since 24 November 2014 and had not been weighed since 15 December 2014. The review did not identify the weight loss or the lack of weight recordings to ensure care was planned to manage and prevent further weight loss.

The registered manager had identified people at risk of poor nutritional intake and had put measures in place to meet their needs. We found however, these were not always followed. For example one person's care plan stated they needed to be weighed weekly and if any changes were noted to seek advice. We found the person had lost considerable weight. They had lost 5kgs from 20 October to 15 December 2014. This had not been identified in the review. This meant the person was at risk of further undetected weight loss.

This was in breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 (1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Health care professionals we spoke with told us the staff were usually responsive to people's needs. Staff called them to seek advice and they said the advice they gave was followed. They also told us staff were knowledgeable on people's health care needs and when they questioned staff regarding people's health and welfare they were always able to give an answer.

There had been a number of safeguarding investigations that had identified poor moving and handling techniques by staff. The occupational therapist had offered to visit the service and train staff in the correct and safe methods of moving and handling people who require assistance. The registered manager has agreed to this and the visit was arranged for 8 April 2015. This will ensure staff have the appropriate skills to meet people's needs.

The registered manager told us there was a comprehensive complaints' policy, this was explained to everyone who

## Is the service responsive?

received a service. However, this had not been followed. Concerns and complaints had not been fully documented as there was no record of investigations undertaken or outcomes. This showed the complaints system in place was not effective. We had received two complaints from people who used the service and two from relatives who told us the manager had not resolved the issues they had raised. The registered manager told us they had resolved the issues, but there was no documentary evidence to support this. This contradicted the information we received from the people we spoke with.

This was in breach of Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 16 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw regular staff meetings had taken place to ensure good communication and effective running of the service. Staff we spoke with confirmed meetings were held and said if they were unable to attend the meeting there was always minutes available so they could see what was discussed.

# Is the service well-led?

## Our findings

At the time of our inspection the service had a Registered Manager who had been registered with the Care Quality Commission since 2014.

There were systems in place to monitor and improve the quality of the service provided however we saw these were ineffective. We saw copies of reports produced by the registered manager. The reports listed areas to check and then these were ticked to say they were satisfactory. There were no actions or improvements identified. The systems had not identified all the issues that we identified during this inspection. For example the care plans had been audited and reviewed, but there were no systems in place to determine if the care plans were effective and being followed by staff. Also the infection control specialist had visited in February 2015 and sent a report with actions required. These actions were not included in the homes environmental and infection control audit which had been ticked in both January and February 2015 indicating everything was satisfactory. The registered manager had not developed an action plan following audits to identify what improvements were required, who was responsible for completing it and what had been done to ensure the action was remedied.

We looked at recent incidents and found 16 safeguarding referrals had been made since June 2014. We found there was no evidence to show the service had monitored these to learn from the incidents and put actions in place to address the issues to prevent them occurring again. The lack of documentation in respect of safeguarding information was not identified through the quality monitoring system. The shortfalls in the recruitment files we found had also not been identified through the monitoring systems in place.

We had received a number of complaints from people who used the service and their relatives. We found these had not been properly recorded by the registered manager and no investigation or outcome was documented. This had not been identified as part of the quality monitoring systems in place.

The registered manager told us staff supervisions had not been carried out. We looked at the supervision records; these showed that staff had received supervision but not in

line with the provider's policies. The registered manager told us due to staff shortages these had been unable to take place. Appraisal was also out of date. The monitoring systems had been ineffective in identifying and taking appropriate action to address this.

At our inspection in April 2014 we identified a number of environmental improvements that were required. The provider had supplied an action plan detailing the maintenance and renewal that they were working through. However the service provides care and support to people living with dementia but the environmental audit had not identified and incorporated best practice in regard to the environment for people living with dementia. Best practice guidance the Assessment Tool from Kings fund 2014, suggests that having different colours on walls and doors makes it easier for people living with dementia to locate things, none shiny plain floor coverings are also recommended.

Any accidents and incidents were recorded, however we found no evidence these were monitored by the registered manager or the provider to ensure any triggers or trends were identified. This meant lessons could not be learned and were not identified by the systems in place to monitor the home.

This was in breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (1) (2) (a) (b) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Satisfaction surveys were provided to obtain people's views on the service and the support they received. The registered manager told us these were due to be sent out at the time of our inspection. Staff meetings took place to ensure good communication.

Staff we spoke with told us they worked well as a team and were supported by the registered manager, but felt they were always very busy as the deputy was working in the numbers of staff delivering care and not assisting the registered manager. We discussed this with the provider who told us they would look into recruiting a deputy manager who could support the registered manager and be provided with some supernumerary hours to ensure adequate support was available.

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

People who used the service were not always protected because the delivery of care did not always meet their needs. Regulation 9 (1) (a) (b)

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider did not have an effective system to regularly assess and monitor the quality of the service provided. Regulation 17 (1) (2) (a) (b) (f)

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

People who used the service were not always protected against the risk of abuse. The provider did not have suitable arrangements in place to ensure people were protected and the provider had not responded appropriately to allegations of abuse. Regulation 13 (1) (2)

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

The provider did not ensure that any complaints raised were fully investigated and so far as is reasonably practicable were resolved. Regulation 16 (2)