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Victoria Lodge Residential Care Home

Inspection report

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Date of inspection visit:
13 January 2016
14 January 2016

Date of publication:
26 February 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 13 and 14 January 2016 and was unannounced on the first day. The home was previously inspected in February and March 2015 when we found four breaches of regulations. These were failing to ensure service users' care and welfare needs were met, not having arrangements in place to protect people from abuse, ineffective arrangements in place to monitor the quality of service provided and not having systems in place to adequately deal with complaints. Following that inspection the registered manager sent us an action plan to tell us what improvements they were going to make. They told us the improvements would be completed by the end of September 2015.

Victoria Lodge Residential Home is a care home providing accommodation for older people who require personal care. It also accommodates people who have a diagnosis of dementia and 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 had 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.

During this inspection we looked to see if improvements had been made since our last inspection in February and March 2015. Although some improvements had been implemented, we found these were insufficient. We identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not always enough staff deployed to meet people's needs. People who used the service and their relatives told us this was in regard to lack of activities and stimulation during the day. They told us the care staff were too busy to be able to take people out or organise activities. We looked at the dependency tool used to calculate staffing numbers but the staffing levels at weekends remained the same as the week days and we could not see this took into account that care staff had additional duties at weekends including cleaning and laundry.

We saw recruitment procedures were in place however these were not always followed as we found not all information was available in staff files to confirm that all the required pre employment checks had been carried out. Staff received supervision, however, this was not in line with the provider's policy and we identified some staff had not been appraised since 2012.

People were not protected against the risks associated with the unsafe use and management of medicines. Appropriate arrangements were in place for the recording, safe keeping and safe administration of medicines but these were not followed. The provider had systems in place to protect people from abuse and staff were aware of the procedures to follow. However, we identified some people had not received their

medicines as prescribed and we made referrals to the local authority safeguarding team.

Staff we spoke with did not understand the legal requirements of the Mental Capacity Act (2005) Code of Practice and how it impacted on people they supported. The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including balancing autonomy and protection in relation to consent or refusal of care or treatment. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and in place so that where someone is deprived of their liberty they are not subject to excessive restrictions. We found the service was not compliant with the conditions of Deprivation of Liberty Safeguards that were authorised.

We found that people had care and support plans in place and these had all been recently reviewed and updated. They identified people's needs and were updated when needs had changed. There were also risk assessments in place. However, we found staff did not always follow the care plans to ensure people's needs were met.

A well balanced diet that met people's nutritional needs was provided. However, we found people were not always supported appropriately to be able to eat and drink. We found best practice guidance was not always followed for people living with dementia in respect of aids for eating and adaptations to the environment.

Infection prevention and control had improved. However, some maintenance and renewal had not been carried out and some areas were not maintained to be able to be kept clean. We also found two trip hazards which although identified by the manager, no immediate action had been taken. This was addressed on the day of our inspection.

We found the systems in place to monitor and improve the quality of the service were ineffective. We also saw the audits did not cover all aspects of the service provision.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff could tell us how to recognise and respond to abuse. However, we found people were not protected as the provider had not always followed procedures to safeguard people.

Appropriate arrangements were not followed for the recording, safe keeping and safe administration of medicines.

There was not always enough staff to provide people with individual support required to meet their needs.

Infection prevention and control measures had improved. However areas of the environment were not well maintained to allow them to be effectively cleaned.

Is the service effective?

Inadequate

The service was not effective.

There were recruitment procedures in place but not all information was in staff files to confirm that all the required pre employment checks had been carried out. Staff did not always receive supervision in line with provider's policies and some staff had not received a yearly appraisal since 2012.

Staff did not understand the legal requirements of the Mental Capacity Act (2005) Code of Practice and how it impacted on people they supported.

A well balanced diet was provided. However, the meal times we observed were task orientated, people were not always given choices and some staff did not interact with people to ensure the meal service was a person centred positive experience.

Is the service caring?

Requires Improvement

The service was not always caring

We did not see any interactions that were not kindly. However,

there was very little social interaction from staff with people who used the service. We did not see that people were supported to be able to express their views or involved in making decisions.

People who used the service and their relatives told us there was not always enough stimulation, activities or community access leading to boredom.

Is the service responsive?

Requires Improvement

The service was not always responsive

We saw people had health, care and support plans. These had been reviewed and updated. The plans identified people's needs and had identified when needs had changed however we found these were not always followed.

There was very little social activity or stimulation. Records we saw and our observations showed people did not have their social needs met.

There was a complaints procedure available to people and their relatives. Concerns and complaints were responded to by the registered manager.

Is the service well-led?

Inadequate

The service was not well-led.

People were put at risk because systems for monitoring quality and risk were not effective. For example, audits to monitor the safety and quality of medication administration were not effective.

Staff told us the registered manager was approachable and did listen to them. However staff we spoke with did not always understand their roles and responsibilities.

There were champions appointed. However from what we observed these roles were not effective and there were no clear values that were understood or promoted by staff.

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 13 and 14 January 2016 and was unannounced on the first day. The inspection team was made up of an adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. Two membesr of the local authority contracts team were also present during part of the second day of our inspection.
Before our inspection we reviewed all the information we held about the service. We spoke with the local authority, commissioners, safeguarding teams and Doncaster Clinical Commissioning Group. The local authority officer told us they had concerns regarding the service and were regularly monitoring. The concerns were regarding MCA and DoLS and lack of staff understanding.

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 spoke with ten people who used the service and three relatives.

During our inspection we also spoke with eight members of staff, including care staff, deputy managers, maintenance person, laundry worker and the registered manager. We also looked at records relating to staff, medicines management and the general management of the service.

Inadequate

Is the service safe?

Our findings

Relatives we spoke with said they felt the people were safe at Victoria Lodge, and that the staff managed them safely. However this did not always reflect what we found and observed.

The provider had safeguarding policies and procedures in place to guide practice. Staff we spoke with were knowledgeable on procedures to follow including whistleblowing procedures. Staff could tell us how to recognise and respond to most forms of abuse but had not recognised that a person not receiving their medication as prescribed could constitute neglect which is a form of abuse. We found some people had not received their medications as prescribed. We identified four safeguarding concerns relating to medication omissions during our inspection and referred these to the local authority safeguarding team.

During our visit we observed that there were enough staff on duty to meet people's care specific needs. Most people who used the service and relatives we spoke with said there were usually enough staff on duty but at times it was very busy. However, all people we spoke with told us they were not enough activities or stimulation.

One relative told us, "There are times when they could do with more staff on duty, but I guess that's the same everywhere you go. It would be nice if the residents could get to go out. But that would mean having staff available to do that."

One person we spoke with told us when we asked if they were alright, "No, what is there to do but sit here or in my bed."

The registered manager showed us the staff duty rotas and explained how staff were allocated on each shift. They said they used an NHS staffing tool to calculate staffing levels, we saw this it was dated 2009. The registered manager told us they did not look at dependency levels of people who used the service but used the calculation in the tool based on a nursing home for 30 people. The registered manager did not take into account that care staff also had additional duties at certain times. For example, on Sundays when the same number of care staff were on duty as in the week they also had do carry out cleaning, laundry and activities. Staff we spoke with told us at times it could be busy at weekends but if this was the case it was the additional duties that did not get done. All staff assured us that people's needs and safety came first.

Relatives we spoke with told us the staff were kind and that their relatives were safe. One relative told us, "They (the staff) have looked after (my relative) well they have put on weight since they have been here which is good; they are safe and cared for."

We looked at recruitment procedures. We found mostly the required employment checks were undertaken. The registered manager told us that staff did not commence work 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.

We looked at the recruitment files of three staff and spoke with staff that were on duty on the day of this inspection. Information within the recruitment files confirmed that most of the required checks had been carried out prior to commencement of employment at the service. However, we found one file did not contain a reference from the last employer and no evidence in the file that this had been explored by the registered manager, who told us it had been discussed. Another file had two references but they were character references, there was not one from the last employer and again no evidence this had been looked into. Another file we saw was an overseas worker, there was no evidence in the file that they were able to work in the UK, the registered manager and the member of staff told us they had leave to remain indefinitely but there was no evidence within their file to confirm this. We discussed this with the registered manager who agreed to ensure all information was available in the recruitment files.

We looked at the systems in place for managing medicines in the home. This included the storage, handling and stock of medicines and Medication Administration Records (MARs) for five people.

The medicines were administered by staff that had received training and had regular competency assessments in medication administration. However, we found staff who administered medication had not always followed procedures. This put people at risk of not receiving medication as prescribed.

We found staff did not always administer people's medication as prescribed. We found staff did not always sign when medication was administered, there was no carried over amounts on the MAR's so it was difficult to determine how many medicines were in stock to determine if the medication had been given as prescribed. Staff had hand written some medicines onto a MAR and when we checked one against the prescription, we found this was recorded incorrectly. The medication was prescribed to be given as and when required however the staff had recorded to give once a day and it had been given regularly. Staff had not ascertained if the person required the medication. We also found that a medication prescribed to be given weekly over a five week period had only been administered once, we checked the amount received with the amount left which confirmed this medication had not been administered.

We found medication for one person was not available in the service and they had not received any medication for three days as new stocks had not been obtained. We observed this person was agitated during our visit and constantly wanted to get outside. The medication they had been prescribed would have reduced agitation and they were also prescribed a strong pain relief, not receiving this medication for three days could have affected their well-being.

We also found another person that had not received their medication for three days due to there being none in stock and two other people's medication was low in stock. One person had none in stock for the next time medication was required in the evening and the other ran out the next day. The deputy manager had only identified this on the day of our visit and faxed a request to their GP's. The arrangements in place were not robust to ensure medication was ordered and received in a timely way. This put people at risk of not receiving medication as prescribed to meet their needs.

We asked the registered manager if there were any protocols for medication to be given 'as required', for example pain relief. They told us there was no one prescribed 'as required' medication. However when we checked the MAR's we found a number of people were prescribed medication to be given as and when required. There were no protocols in place. One person was prescribed two different types of pain relief. We asked staff when the different pain relief medicines would be required but they were unable to tell us and there was no protocol in place to be able to determine when to give which pain relief medicine We also

found some people who were prescribed pain relief medicines when required, did not have capacity to be able to verbally tell staff when they were in pain. The protocols would have given guidance for staff to determine how people presented when they were in pain and needed medicine for pain relief. This meant the people could be in pain and not have pain relief medication administered as staff did not know what signs to determine if pain relief was required.

We were shown medication audits. The audits had not identified the errors we found and were not effective. For example the previous audit had not identified that on many occasions staff were not signing the MAR to evidence medication was administered or that there was a poor audit trail of medicines stock levels.

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

We had been provided prior to our inspection with a report from the infection prevention and control nurse specialist who had carried out a visit to the service on 29 September 2015. They had over a number of visits seen improvements. However, they had advised improvements in the laundry which had not been carried out and the sink in the laundry was being used by the cleaner to obtain water for the cleaning. There was not a dedicated cleaning sluice sink. We discussed this with the registered manager who agreed there was room in the cleaners room to install a sluice sink. This would mean the cleaner had a dedicated sink for also disposing of the dirty water and would reduce the risk of cross contamination.

During our inspection we carried out a tour of the building. We looked at the cleanliness of the environment and the maintenance. We found predominantly the environment and equipment was in a clean condition. However, we identified some areas that were not well maintained and this made it difficult to clean. For example the sink units in bedrooms were constructed of untreated wood; some were stained and as they were porous they were unable to be thoroughly cleaned.

We found in some communal bathrooms there were personalised products. For example combs, hairbrushes, baby powder, razors and shampoo. These should be in people's bedrooms so they are not available for other people to use. We found in one bathroom clothing piled on top of the clinical waste bin and the pedal bin used for disposable paper towels, was positioned on a ledge which could not be accessed. We discussed this with the registered manger but the products were not moved, however the care staff we spoke with regarding the clothes did move these.

We also identified an area of damaged flooring at the small lounge dining room by the entrance door and the edging strip at the threshold to the doors was raised, which could cause a tripping hazard. We had identified a person who used the service had fallen and tripped in this area on 31 December 2015 and although it was not witnessed staff told us where the person was found. The registered manager had identified it on an audit they showed us they had completed the day before our visit dated 12 January but had not taken any immediate action to address this. As it was possible this may cause a person to trip and fall we requested this was looked at urgently to ensure people's safety. The registered manager had this repaired during our inspection and a new floor covering was ordered to be replaced the following week.

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

At our last inspection in February and March 2015 we found a breach of regulation 9 HSCA 2008 (regulated activities) regulations 2010. People did not receive care or treatment that met their needs, as we found care plans and risk assessments were not always in place, reviewed or updated. This corresponds to regulation 12 HSCA 2008 (regulated activities) regulations 2014.

At this inspection we found the registered manager and deputy had reviewed and updated all care files. People's needs were identified and if needs changed we saw these were reviewed. For example, a person had fallen and been admitted to hospital and on their return to the service their care plan had been updated with their changes in needs. Risk assessments were in place and measures to reduce risk had been identified. However, we found that these were not always followed. For example one person's care plan stated they could become agitated and to 'give medication as and when required'. We observed this person was agitated during our inspection, however, medication had not been given as the medication was not in stock.

Staff did not understand the legal requirements of the Mental Capacity Act. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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 is called the Deprivation of Liberty Safeguards (DoLS). DoLS requires providers to submit applications to a 'Supervisory Body' for authority to do so. As Victoria Lodge Residential Home is registered as a care home, the Care Quality Commission is required by law to monitor the operation of the DoLS, and to report on what we find

The registered manager had made a number of applications for people who used the service to be assessed in line with the guidance. However they had on a number of occasions been asked by professionals to submit applications, it had not always been the registered manager determining that an assessment was required. Feedback we received from the safeguarding adults DoLS team was that applications contained mainly generic information that suggested information was copied and pasted from referral to referral and not properly reflective of the care arrangements for the individual that may amount to a deprivation of liberty. They also told us the information on the application forms was still to a poor standard. We were told that free training had been offered by Doncaster council but the provider had not accessed this. The registered manager told us at the inspection that they were now booked on the training at the end of January 2016 however we have been informed they did not attend this training.

When we spoke with care staff we found they were not knowledgeable about mental capacity and how this impacted on the people they supported. Staff including one of the deputy managers did not know who had an authorised DoLS and if there were any conditions. At the time of our visit there were five authorised.

Therefore staff who were providing care and support which required consent were not able to apply the codes of practice associated with the act.

We also found where people who did not have capacity to give consent, best interest decisions were not always made or recorded in people's plans of care. We identified best interest decisions regarding doors being locked and no access to the outside, were not completed.

This was a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
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Staff said they had received supervision, although these were not carried out in line with the providers policy. Staff also said they had training that helped them to understand their role and responsibilities. However, from what staff told us and what we observed this did not always reflect this and it was not clear if the training had been effective. The training records we saw showed staff had received some training and induction, staff also had nationally recognised qualifications to level two and three. We identified not all staff had attended training in MCA or DoLS which is important for services providing care to people living with dementia.

Staff were also not aware of good practices when caring for people living with dementia. The home did have a dementia lead but they were on maternity leave and no one had taken the role during this period. For example one person was nursing a doll during our visit and had a number in their bedroom, when we asked staff if they had knowledge of doll therapy or received any training they said not. Doll therapy can relieve anxieties and increase positive behaviours. The Alzheimer's society state that if a person becomes attached to a doll in a positive way then it would be helpful to provide a crib and not to call the doll a doll as to the person it may be their child and be bringing back happy memories. The staff we spoke with did not understand the importance of this for the person and no crib had been considered.

We identified five people who had an authorised DoLS in pace, two of these had conditions in relation to their authorisation. We identified these were not being followed. For example, one person's condition was to access the community with staff support at least twice a week, there was no evidence this was happening yet during our visit the person had their coat on and asked on a number of occasions to go out. This was not ensuring the persons needs were met.

We found that although some changes had been made to the environment to improve the lives of people living with dementia. The toilet doors had been painted a different colour and had good signage for people to be able to see what the room was. However, we identified there were still areas and many things that could be further improved. The registered manager told us the service was providing care to people who were living with dementia and they said that everyone who lived at Victoria Lodge had a diagnosis of dementia. We also found on the website that they stated they provided dementia specific care.

We found the walls were painted a light cream and the bedroom doors and frames were white and it was difficult to differentiate between areas. There was no visual stimulation, no identification on bedroom doors for people to identify which was there room, bedrooms were very sparse and bare. There was little attempt at providing memorabilia or reminiscence material that people could identify with or would offer subjects for interaction with people.

Many of the bedrooms were not personalised and did not have any personal effects. We asked on two occasions if the rooms were actually occupied by people, because the rooms looked so bare and not lived in. The bed linen on most of the beds we saw was all light in colour and we saw it was also in a poor

condition as the fabric was thin and worn. Most of the environment did not meet best practice guidance for people living with dementia. For example the 'Environmental 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. Guidance funded by the university of Stirling also found, 'People feel more at home when they have familiar objects around them. In care home settings it is important that people are able to personalise the furnishings in their rooms.'

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we spent time in the two dining areas during lunch. We observed the food service and staff support. We observed that tables had plastic cloths; there were paper napkins and some salt cruets. People were offered a choice of three juices but no hot drink choices. Staff wore plastic disposable aprons. We observed staff gave people plastic aprons to wear, staff did not always ask the person first before they put on the apron. We saw hot drinks and biscuits were served in-between mealtimes. A relative told us, "I am not here at mealtimes so cannot comment on them but I don't think there are any menu`s, I haven't seen any."

We also found people were not always given choices and staff did not interact with people to ensure the meal service was a positive experience. We saw people were just given a meal no choice was asked when they sat down, no menus were on the table and no picture menus were available to assist people living with dementia understand what the meal choice was. The cook told us, "I know what all the residents' likes and dislikes are and what they want. I go round and ask them in a morning which choice (of two) they want for dinner they are the ones that are important, sometimes I could do four or five different things at lunchtime if that's what they want." We saw no evidence of this. We were shown a four week menu but his was not being followed and the cook was writing on a scrap of paper what they had served we only saw two choices each lunchtime and it was sandwiches every evening. We were shown the list kept of what people choose to eat; this gave person name and then main course but this was just ticked and would not evidence what they had chosen or eaten as it did not show a choice.

We saw that some meals were simply placed in front of people with little interaction. When putting meals in front of people, there was no other explanation or checking if indeed that was what that person expected or wanted. The food looked appetizing and was plentiful and people told us the food was nice and they always enjoyed the meals. One person told us, "I like the food and meals there's always so much of it I feel bad leaving food, but they do give you a lot of it."

We observed a person eating who appeared to have a visual impairment. We saw that they were struggling to see what was on their plate and was not able to get the chicken on their fork. They asked for a spoon, saying, "Can I have a spoon, I can't see my chicken." When they put a their food into their mouth, they shouted, "Oh no, cabbage, I hate soggy wet cabbage." The carer took the cabbage off the plate for them, however, if they had been given a choice this would not have been served to them. Staff did not appear to know they did not like cabbage. We also saw the person had difficulty chasing food around their plate in order to get it onto a spoon. There was no special plates used and we did not see any specialist equipment such as plate guards, or partitioned plates used to assist people eating independently and respect their dignity.

There were two lunch sittings. We were told the first sitting was for those people who were independent and the second sitting was described as for "Feeders" (residents who required some assistance with their meals). All staff we observed and spoke with in relation to this task referred to people who required assistance to eat their meals as 'feeders' which showed a lack of respect for people who used the service.

We observed the second sitting and the people who ate at this time required assistance with eating their meals. We observed two care workers assisting people. One care worker was very communicative and informative with the person they were assisting. The staff member informed the person of what the food was on their plate, and made the eating experience a good one by chatting and informing throughout. The other care worker was less communicative with the person they were assisting and hardly spoke to them throughout the meal, it was very task orientated. Other staff shouted over people during the meal. One care worker at the beginning of the mealtime shouted across the room to another member of staff, "Have we got (person name) thick and easy ready?" Informing everyone that the person required food thickened lacking respect and not maintaining the person's dignity.

We saw one person did not eat anything at lunchtime and left the dining room to wander around the home. We observed the deputy manager ask, "Would you like something different?" but did not follow or further ask the person who just wandered off. When we later spoke with the registered manager they told us the person liked puddings and often didn't eat their meal, the staff did not offer the person a pudding instead of the main meal. This meant staff did not always understand people's needs and how to respect them.

This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

Generally people and their visitors we spoke with were happy living at Victoria Lodge. A relative we spoke with said, "They are a nice lot here, kind and caring, it's not easy working here I am sure with these residents, they always seem to have patience with them." A relative said, "I think the staff do a grand job really considering how intense and hard it is here. They need constant attention going to the toilet and everything and there's always something needs doing. I think the staff are kind and caring."

Visitors and relatives we spoke with told us they felt the people who used the service were treated with dignity and respect. We saw and heard staff speaking appropriately to people.

A person told us, "I like to have a bath and the carer looks after me when I do – they are very kind and make me safe."

Some relatives felt there could be some improvements. One relative said, "They are all quite good. Some are better than others though, I know I came one night and one of the residents was swearing a lot but the carer did not address it, it was as if they wasn't too bothered."

Another visitor said: "I wish the staff could spend more time, like one to one and take them out a bit though."

A person told us, "There is nothing to do apart from sit here or in my bedroom, I am bored." There were activities ongoing during our visit the registered manger had asked staff to come in for an extra shift to deliver activities. However records we saw did not evidence that activities took place on a regular basis. People and relatives we spoke with all commented that there was not much to do apart from watch television.

A visiting friend said: "I know about the care plan and have been involved in the care of my friend for a long time now. I do think they care and show love here for people."

We observed some staff being kind and caring towards the people who used the service and many were patient. Staff were very helpful and willing. We also observed a number of people who were wandering around the home; staff were distracting and re-directing them to other parts of the home in a caring way.

However we observed some areas where people's dignity was not promoted. We saw one person in clothes after the meal that were badly stained with food. The clothes were not changed or any assistance from staff seen to encourage the person to go to the bathroom to be cleaned. The person did not look well-presented and staff did not promote their dignity. We also observed clothes in the bathroom ready for a person who was to have a bath we were told by the care worker they were clean, yet the underwear we saw was very badly stained. The care worker did acknowledge this and said they should have been soaked, they said, "They are often stained as it is difficult to clean sometimes." Dressing people in strained underwear did not promote their dignity.

Staff did not always respect how people liked to be presented before they came to live in the service. One relative told us, "(my relative) was fastidious in her younger days in her dress and hair and things – and sometimes I think it's sad she's not like that now, however, she is not distressed and doesn't know. I have stopped buying clothes for her now, she just wears what they put on her here." People's preferences should not change because they are living with dementia and their appearance should be maintained to ensure their dignity is respected.

We saw there were designated champions in dementia and infection control but the registered manager had not identified dignity champions. It was also noted the dementia champion was on maternity leave. It was not clear from speaking to staff if they fully understood the roles of the champions.

This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also found staff did not fully understand people's needs living with dementia. For example staff did not understand the importance of the colour of crockery when serving meals, Kingsfund assessment tool is an example of good practice guidance, which states serving meals on coloured plates enable people living with dementia to be able to see the food better as it provides a contrast.

We observed staff did not always know peoples preferences. For example one person who was partially sighted was served cabbage with their meal when they put this in their mouth they said they did not like cabbage, staff should have known their preferences.

Although we saw staff did seek consent before giving care or support we also saw examples where staff did not always involve people in decisions. For example,at lunchtime people were given plastic aprons to wear they were not asked if they wished to have an apron on. We observed people who required assistance with their meals being referred to as 'feeders' and staff talking to each other over people who used the service.

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in February and March 2015 the service was in breach of regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to regulation 12 (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment.

At this visit we found care plans had been reviewed and updated to identify people's needs and ensure how to meet their needs was documented. The care plans were reviewed when people's needs had changed. However we found these were not always followed. For example they detailed people's medication needs and social stimulation needs which we evidenced had not been followed to meet people's needs. It was also not clear from plans if the people had involvement in their plans of care. Although one relative told us, "I know about the care plan and have been involved with the care." Another relative said, "I am always kept well informed and I know if they need to get the doctor or anything then they let me know."

We identified during our visit that reasonable adjustments had not always been made to ensure people received the support and equipment they needed to stay independent. For example one person who used the service had a visual impairment, when they were given their meal we saw they were struggling to eat the food was falling off the plate as they were trying to get it onto their spoon. The person had been given a fork but had asked for a spoon as they felt it would be easier. There was no plate guard provided for the person to be able to eat independently.

The registered manager told us there was a new activity coordinator in post. We saw there was an Activities Programme displayed on the notice board outside the kitchen. This was a four week programme showing things like: sing a long; board games, arts and crafts, one to one; outside visiting, Bingo, Manicure and hand massage; Reminiscence. However what people told us and from our observations this did not reflect that this took place. We found the staffing levels did not allow staff time to provide activities, stimulation and effectively engage with people who used the service.

The registered manager told us the new activity coordinator was employed to work Monday to Friday, 5 hours a day. On the days of our inspection they had called in sick. They told us activities were taking place. However, when we checked records this was not evidenced and many people who used the service had not been recently involved in any meaningful activity. The activity records we were shown, detailed activities people had participated in. The records detailed activities until November 2015 after which there was very little documented as taking place. For example one person had no records of participating in activities since 4 November 2015 and another person in two months from 11 November 2015 had only participated in two activities. One stated an activity as 'nails filed and painted', 29 December 2015 and another 'played skittles' on 12 January 2016. This did not meet the social needs of people who used the service.

In the afternoon we also saw three staff siting in the lounge they were completing paper work and were not engaging with the people who used the service.

We did see some activities during our inspection such as people playing dominos and a game of bingo, as

the registered manager had asked an additional care worker to come in to provide activities. This had been requested after we had arrived to carry out the inspection. We also saw a member of staff playing cards with one gentleman, and later having a game of dominoes with three people who used the service. In the afternoon there was a game of bingo taking place in the main sitting room, the expert by experience participated in this to assist a person who was partially sighted so would not have been able to participate without assistance. People who were participating in the game of bingo told us they couldn't remember playing bingo before. During the game the television was on loudly, we had to request the volume be turned down in order for the people to be able to hear the bingo caller.

People and relatives we spoke with told us there was lack of stimulation and social activities. One person told us, "I'm fed up, bored nothing to do." A relative said, "They used to do arty things sometimes, but that was about a year ago. Nothing much since really, I don't think there's anyone dedicated."

Another relative commented, "I am not sure about activities happening. I know two church wardens come around and have a sing-a-long now and then. I have seen them. Some staff don't seem to care so much as the others. (my relative) likes to go out for a walk but they do not have the staff to do it."

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a complaints' policy, the registered manager told us this is was explained to everyone who received a service. We did not see this prominently displayed. When we asked staff they showed us a file that was titled 'comments and suggestions' when we looked at this it was signed by the previous registered manager who had not worked in the service since 2012. The only comment in the file was dated 2013. Most people we spoke with told us they would raise a concern with staff or the registered manager. One relative said, "If I had a niggle or complaint about my relative, I would go to the office and see the manager straight away, It's always best to sort things out there."

We did see one complaint the registered manager had investigated, they told us this was the only concern that had been raised in the previous year. This showed outcomes and conclusion and that the person was listened to. However the local authority has told us they received a complaint and when they visited the service to investigate they were not allowed entry to the home.

Before our inspection, we asked the local authority commissioners for their opinion of the service. The local authority officer told us they had concerns regarding the service. These were regarding care plans, activities, DoLS and safeguarding. The officer told us they had seen improvements in some areas but were still monitoring the service to ensure people were safe.

Inadequate

Is the service well-led?

Our findings

At the time of our inspection the service had a registered manager. They registered with CQC in January 2015. Although they had worked in the capacity as manager since 2012.

At our previous inspection in February and March 2015 we found a breach of regulation 10 HSCA 2008 (regulated activities) regulations 2010. Regarding assessing and monitoring the quality of service provision. This corresponds to regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance.

At this visit we found systems to monitor the safety and quality of services had been put in place but were not effective. For example we looked at the medication audit but these did not identify the issues we found during our inspection therefore improvements required had not been identified to ensure medicines were managed and administered safely.

We also found ineffective monitoring of staffing to ensure adequate staff were deployed to meet people's needs. We also found the monitoring systems had failed to address that some staff had not received an annual appraisal since 2012. Staff training was not monitored to ensure it was effective and staff did not always receive supervision within the providers timescales and we identified poor knowledge and compliance with DoLS, conditions not followed and staff unaware who had an authorised DoLS in place and lack of understanding of people living with dementia.

We were shown the last provider audit dated 9 September 2015. This identified a number of areas that required actions. However, this did not identify who was responsible to complete the action to be taken and there were no timescales for completion. For example it identified appraisals needed to be completed, we identified that staff had not had appraisals since 2012 and new staff after this date had never received one. Therefore the audit was not effective as actions had not been carried out. The audit also identified that training was complete but did not cover the effectiveness of the training.

The audit also contradicted the information the registered manager told us. The audit stated supervision should be every six months, the registered manager told us they should be completed every three to four months.

The registered manager had audited incidents and accidents and the times of the incidents. However they had not identified from this that there was a high number of incidents during the night where people were found on the floor and documented as an unwitnessed fall. We also found a lack of regular activities and stimulation for people who used the service as people told us there were not enough staff to provide these. The registered manager had failed to analyse the information and determine if there were sufficient staff that were adequately deployed to ensure the care and social needs of people were met.

At our inspection in December 2013 we had identified that the safety of the premises required improvement. The registered manager who was acting at that time compiled a maintenance programme that we saw on

our follow up inspection in February 2014. The programme detailed a two year plan working throughout the building. We were shown this plan at this visit and it had not been completed. We also identified that some areas were still requiring improvement and had not been remedied since we identified them in 2013. For example the sink units in some people's bedrooms were constructed of untreated wood which were stained and unable to be thoroughly cleaned. The audits had been ineffective in identifying this and ensuring the maintenance programme had been adhered to. The provider did employ a maintenance person who during our visit was working to improve areas we had identified required attention. Relatives also told us they had seen this staff member working hard on occasions they had visited.

We identified that people who used the service were living with dementia, the registered manager told us all people living at Victoria Lodge had a diagnosis of dementia. We also saw on the provides website that they have an ethos of personal centred care and dementia specific care. Yet we found the delivery of care and support was not reviewed against current best practice guidance.

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they felt supported by management and that they were approachable. One staff member told us, "I can talk to the manager at any time." The service had also achieved investors in people in September 2015.

People and their relatives we spoke with told us the manager was approachable. A visiting relative told us, "If I had an issue I would go to the manager, she seems approachable."

Staff told us that they had received supervision with the manager and felt they were supported. or deputy but this to date had not taken place regularly.

Staff told us that they had staff meetings but that they felt communication was good between staff on a daily basis. They had a hand over at the change of shift to ensure staff were informed of any changes.

Satisfaction surveys were undertaken to obtain people's views on the service and the support they received. We saw they had been sent out the in October 2015. These were sent to relatives and, health care professionals. Predominantly these were positive and many stated they had seen improvements. The registered manager told us they were sending out surveys to the people who used the service but staff had to go through the questions with them as not everyone was able to complete the survey without support.

Relatives we spoke with told us they had been asked to complete surveys one told us, "I was asked to complete a questionnaire a while back now, two questions, which I did."