Heritage Care Homes Limited

Victoriana Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Victoriana Care Home is a residential care home providing personal care to 27 people. The service can support up to 33 people. The service supports people in property over three floors.

People's experience of using this service and what we found

We found multiple issues in relation to poor hygiene and infection control practices at the home. Key safety risks were not being identified, assessed, and action taken to reduce these potential risks. The management team and provider were not always promoting the safety of people who had a history of mental health needs. When we raised these issues to the registered manager they took action to start to address our concerns.

Staff did not always have a complete knowledge and understanding about how to protect people from potential abuse. Risk assessments for people were not up to date and completed in full. People's medical creams were not being stored and monitored in a safe way. Recommendations by a provider of fire related equipment had not been acted upon in a reasonable time frame.

People did not speak negatively about the food, but they equally did not speak positively about it, they thought it was ok. The meal experience was basic and was not promoted as a pleasurable experience. The service did respond when people were at risk of being an unhealthy weight.

People had input from health and social care professionals, but key health appointments such as dental and chiropody were not always happening or being effectively monitored to ensure people also had this health input. Staff knowledge and practice was not always complete in terms of managing people's needs and safety. Staff felt supported by the registered manager and felt they could approach them and raise issues when needed.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service were not always supporting this best practice. The registered manager was assessing people's mental capacity, but this was not always in line with best practice.

The provider was not promoting people's dignity in relation to their experience of care and the environment they lived in. Sometimes staff were not respectful to people, at times staff behaved in an institutionalised way with people.

Staff did not routinely engage with people in a friendly and personalised way. They had not formed or tried to form good relationships with people. There was a lack of social stimulation, in terms of conversations activities and events. The management were not trying to promote people's interests or enable them to form new interests and goals with life.

The provider was not completing robust and meaningful audits and checks of the service. The registered manager told us they felt supported by them. However, we found the provider was not effectively assessing the service, to help improve people's experiences at the home.

The registered manager was working creatively with some people to promote their independence, ensure they stayed connected to friends and stayed motivated to engage with services provided by health and social care professionals. The registered manager was also supporting people to have holidays. However, this good practice, had not filtered down to all staff and had not influenced the general culture of the home.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection

The last rating for this service was Good overall with Requires Improvement in well led (published in 24 April 2018).

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches in relation to the governance of the service, the safety in terms of hygiene and people's experiences in living at the home.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.
Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.
Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not caring.
Details are in our caring findings below.

Inadequate

Is the service responsive?

The service was not always responsive.
Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.
Details are in our well-Led findings below.

Inadequate

Victoriana Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was completed by one inspector and one assistant inspector.

Service and service type
The Victoriana is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We spoke with the local authority to seek their views of the service. We reviewed the information the provider is required to send us. We used all of this information to plan our inspection.

During the inspection
We spoke with seven people who lived at the Victoriana Care Home. We spoke with the registered manager,

deputy manager and four members of staff. We completed many observations during the inspection. We looked at safety records, complaints, care records, people's medicines, staff records and other records relevant to the management of the service.

After the inspection
We sought clarification about action taken by the registered manager about some of the issues we had found.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

● The home was not clean. We found infection control risks in multiple places about the home. A person had a dried old brown stain on their seat of their armchair in their room. Their mattress had yellow stains on it. There were marks on the walls near people's beds. Furniture was marked and dented in places, which is an infection control risk. A crash matt was unclean.

● There were brown stains around the door on a toilet near the lounge. This room had just been cleaned but this had not been identified. We needed to tell three members of staff, including the deputy and the registered manager about this. Still no action had been taken. We then had to show the deputy manager before action was taken

● Communal bathrooms were not clean. One person's room and their en-suite were unkempt and required a thorough clean. In the kitchen the cooker hob was encrusted in thick black mater which came off as you touched it. Frying pans in use were also covered in this mater. We spoke with the registered manager about this. They arranged for additional hours of cleaning to take place each afternoon. They arranged for a 'grab bag' to be made available for staff to respond to hygiene issues.

Assessing risk, safety monitoring and management

● Risk assessments were not complete, and some were out of date. The home was supporting people with mental health needs. One person had historically expressed suicidal thoughts. These risks had not been meaningfully assessed. About the home were ligature risks in bedrooms and bathrooms which could be used to self-harm. For example, a pull cord for the call bell was left on top of a toilet in a closed room. It was unclear if this posed a risk to people or not.

● One person had a lighter in their room. A smoked cigarette end was found in one unused bedroom.

● A person had a heater on and a separate air modifier unit on in their room. It was very hot, and these units were warm with dusty vents. The registered manager and staff had not considered this as a fire risk.

● A cupboard with builder's equipment in it was left unsecured near people's bedrooms. Discarded metal bars belonging to a piece of equipment were left in a bathroom. On the top of a person's wardrobe two metal bars were hanging on the edge of the wardrobe. We needed to ask for these to be removed and the work man's cupboard made secure.

● A recommendation from the fire service to replace the smoke alarms as they were ten years old was made in July 2019. This work had only been partially completed by late October 2019. The management team was not testing for Legionella. This is a virus which can enter through water systems and cause people to become unwell. People's evacuation plans were not up to date.

● We spoke with the registered manager about these issues. They completed risk assessments for those at risk of self-harm and took other actions to promote people's safety.

Systems and processes to safeguard people from the risk of abuse

● The registered manager had a clear understanding about how to identify and respond to potential concerns about abuse. However, the staff we spoke with did not all understand what abuse could look like, or what they should do about this.

● Some staff knew they should report their concerns to the registered manager, but staff did not all know who else they could report their concerns to outside of the home.

Using medicines safely

● People's prescribed creams were not stored in a safe way. Creams were in use with no open dates recorded so there was no way to know if the cream was now ineffective or not. One person's cream had been dispensed in May 2019 and should have been discarded after three months of opening. This was still in use. We raised this with the registered manager, these creams were then removed and discarded.

● Some creams were stored in people's rooms; the temperature of these rooms was close to the maximum recommended temperature for storing medicines safely. The medicine's cabinet was also repeatedly close to the recommended temperature. There was no plan in place or action taken to respond to this potential risk.

● We completed a check of the medicines. Out of the three medicines we looked at, one medicine count did not tally with the recorded administered medicines. The deputy manager said this may be due to a system failure with the medicines electronic system, which the service used. However, no action was suggested to resolve this issue.

We found no evidence that people had been harmed however, people's safety was not being reviewed and effectively managed at times. This placed people at potential risk of harm. Action was taken in response to what we found, but systems at the service did not identify these safety issues. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Safe recruitment systems were in place to ensure people were safe and being supported by staff who were suitable for the role. New staff had a DBS. (Criminal records) check. Identities of staff were verified and references were obtained.

● There appeared to be sufficient staff to meet people's needs. However, there were clear shortfalls with the deployment of staff. The home was using agency staff who were not being instructed about how to actually support people.

Learning lessons when things go wrong

● Lessons were being learnt when we identified issues to the registered manager. However, the management team were not doing this on a routine basis or identifying issues for themselves.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- The management team and provider had not ensured that people had holistic assessments which made use of best practice guidelines and involved other professionals. For example, people's mental health needs were insufficiently assessed and reviewed.

Staff support: induction, training, skills and experience; Staff working with other agencies to provide consistent, effective, timely care

- Staff spoke positively about their inductions and the training they had received. However, staff were unable, or struggled to give us examples of how their inductions or particular training sessions they had attended, was useful to their work.
- Agency staff did not have an effective induction to their work. The training supplied was not sufficient to prepare them for their role. These members of staff often looked lost and unsure what to do. They did not have effective support or direction during their shift.
- Training was up to date and new training had been scheduled for later this year. The registered manager had reviewed the training available and updated this to ensure it was relevant to people's needs. However, we identified shortfalls in staff knowledge which questioned how effective training had been. For example, infection control, health and safety, and mental health.
- The registered manager and provider had not considered other ways to promote staff's knowledge and understanding in areas relevant to people they supported.
- The registered manager had arranged for staff to have competency assessments in various subjects. These checks were taking place on a regular basis and were well evidenced. However, this standard of care was not found at the home.

Supporting people to eat and drink enough to maintain a balanced diet

- People told us the food was ok, but they did not speak about it in a positive way. One person said, "It's alright." Another person said, "It's satisfactory."
- The meal times lacked a social atmosphere and it was not promoted as an experience. Staff wore aprons and gloves when handing people their plated food. A person was also supported to eat their food, by staff wearing gloves. In the centre of the lounge the left overs were scrapped into a large bowl. This was left until the meal time had ended. The medicine trolley was in the dining area and a member of staff gave some people their medicines during this time. Staff did not engage with people. At times the patio door was opened letting cold air into the room. We observed it to be an institutionalised experience.
- People were not being involved in what they were being offered to eat and drink. The chef told us that the

menus were last updated 18 months ago. At this time, the chef and the registered manager asked people about what they wanted to eat. Techniques to promote choice for people living with memory issues were not being used. People told us their favourite foods and drinks were not being offered.
● A system was in place to monitor people who were at risk being an unhealthy weight. Although records of how much people had eaten and drunk did not have target amounts with action for staff to follow if people did not meet these targets.
● People's weight was being monitored. However, the weighing scales were not being serviced to ensure they were accurately recording people's weight.

Supporting people to live healthier lives, access healthcare services and support
● People had involvement from social care professionals. The registered manager was seen consulting and sharing information with these professionals during the inspection. Referrals had been made to physio's and specialist food teams when appropriate.
● Although, we identified when people had requested to see a dentist and chiropodist, action had not been taken. We raised this with the registered manager who later told us this had been actioned.

Ensuring consent to care and treatment in line with law and guidance
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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● The registered manager was completing mental capacity assessments when this was needed. However, often what was recorded in the assessment was generic and it was not personalised.
● We also noted that one person had multiple assessments about certain decisions in one day, this is contrary to best practice guidelines. Further work was needed to comply with the MCA.

Adapting service, design, decoration to meet people's needs
● Work had been completed to help people living with dementia and memory issues find the toilets. A space was being developed to give younger people at the home a space to relax in and use.
● There was inadequate signage about the home, to help people living with dementia find their bedrooms. The menu was placed high on the wall and there were no picture menus available about the lounge and dining room.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not treated with compassion and there were breaches of dignity and respect.

Respecting and promoting people's privacy, dignity and independence
● The provider and the management team were not promoting people's dignity and respecting the environment. There had been a lack of investment for some time into the building. People had tired and well used bed linen and towels. One person said their fitted sheet kept coming off the bed because it was too small. There were marks on the walls. One person had no head board for their head. Furniture looked tired and was stained. A person had clothes airing in their room, some of it was stained.
● We saw one person had a stained tooth brush and other people had used disposable razors in use which were covered in hair.
● There was institutionalised practices and the home was not inviting. Staff were not effectively monitoring the hygiene of the home. There were signs about the home. For example, one about inappropriate behaviour towards staff and another saying drinks were available upon request. Staff stood about the lounge often with their arms folded.
● Drinks were poured without asking people what they wanted. Staff spoke amongst themselves in an open way about people in the home. Staff referred to people as "She" and "He" without using people's names. One person was wheeled into the lounge in a wheelchair and left facing a chair. This member of staff did not speak with this person, they walked off and left them.
● Wording in one person's assessments were not always respectful, one person's mobility was described as, "A strange gait." In another person's assessments the way their challenging behaviour was described was not always adult like.

We found no evidence that people had been harmed however, people's dignity was not being promoted at the home. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's confidential information was not being stored according to best practice in the registered managers office.
● Some people's independence was being promoted by the registered manager in terms of going out of the home. However, more work was needed in this area to promote independence with elements of day to day life.

Ensuring people are well treated and supported; respecting equality and diversity
● We saw some staff were polite to people. One person requested a lot of support, staff consistently responded in a kind way to them.

● At other times staff did not respond to people when they were showing signs of frustration. One person said, "I want to blow this place up." Staff walked past and did not engage with this person. Another person swore, and staff did not check if this person was ok. We raised this with the registered manager who agreed staff should have spoken with these individuals.
● A member of staff was talking with a person who was living with dementia. They were getting confused about whether their relative was visiting that day saying, "So [relative] is coming today?" This member of staff leant over the table and said in an abrupt way in front of other people, "No you told me that." This person said, "Oh." They did not look happy, nor was this situation resolved.

Supporting people to express their views and be involved in making decisions about their care
● Some people were being involved with elements of their care planning. However, this was not consistently the case, for example regarding people's risk assessments and their experiences at the home.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● Assessments of people's needs were not all in place. There was also a lack of detail about people's interests, past achievements, aspirations and goals for the near future.

● People were not having person centred reviews, with people being asked about the care they received and their experience of living at the Victoriana. Staff and relatives were not being involved, when appropriate with these conversations.

● Staff's knowledge of people's needs, and interests were basic. Often staff did not know about people's assessed needs and how to support them.

● We were told about two people living at the home where the registered manager had reviewed their needs and with consultation from professionals were working with them to promote their independence and interests. The registered manager spent time with these people talking through their issues and supporting them in the community. Although this was positive this was not happening for other people at the home.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● We were told about some people where the registered manager had supported them to access friends, the local area, and go on holidays. This was positive, but there was a lack of stimulation and social times with people day to day. One person said, "Well you can see, there isn't much going on, we are all bored stiff." Another person said, "[Name of person] had said they wanted to dance, but no one did anything about it, [name of person] should be able to dance everyday if they want to."

● We saw that people sat about all day and evening. Some sat in front of a TV which was on a constant loop of one channel. Others walked about the lounge. Opportunities were missed, and staff did not engage with people. One person said, "Not really stimulating here, pretty sad place really."

● One person appeared low and bored. Often, they swore in a low voice. No time had been spent with them working out what they wanted to do. We observed that they had a good rapport with a member of staff and we made some suggestions to the registered manager about improving their experience at the home. The registered manager later told us they had started to implement these plans with the person. The management team and staff were not doing this kind of work with people instinctively themselves.

End of life care and support

● End of life plans were not being completed in a meaningful way at the home. The registered manager had identified this shortfall and enrolled some staff and themselves on end of life training, which was provided over a period of time.

● This training had started but these conversations with people about their end of life needs had not. This

was a missed opportunity as this could have contributed to staff development in this area. The registered manager agreed with us and said they would start having these conversations with people.

We found no evidence that people had been harmed however, people were not receiving consistent, high-quality person-centred care on a routine basis. This was a breach of regulation 9 (Person-Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's communication needs were being identified in people's assessments. One person was living with a communication difficulty. We saw staff support this person access the lounge and garden. However, at lunch they removed their plate without checking they had finished. They said after the plate had been removed, "Where's that gone, what was left on it?"

Improving care quality in response to complaints or concerns

- There was a complaints process in place. The registered manager had responded to issues raised by relatives and people. The registered manager had apologised when things had gone wrong.
- Their responses to complaints did not tell people what they could do next if they disagreed with the response.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The registered manager's and the provider's quality monitoring checks were not adequate to identify issues and make plans to try and resolve these. There were key safety and hygiene issues which were not being identified. Staff were not being trained or enabled to be part of the quality monitoring process at the home.
- The provider was visiting the home weekly, but they were not assessing the service to support the registered manager and the service to make improvements. We identified multiple issues and shortfalls which should have been addressed and found through effective quality monitoring systems, but they were not.
- The service was supporting more younger people with different needs to what the service had historically provided support for. However, the registered manager and provider had not made a clear plan about how they were going to do this.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There were elements of a positive culture in terms of the actions of the registered manager and their approach to supporting some people with their well- being. The registered manager was working with professionals and the person, to promote some people's well-being and their independence. However, this had not filtered down to all staff. There was not an active culture to create good outcomes for everyone and ensure people had positive day to day experiences at the home.
- There was an action plan to improve the structure and environment of the home. However, this had not identified all the issues which we had found.

We found no evidence that people had been harmed however, effective auditing systems were not in place to promote robust quality care. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- There was a lack of provider active participation in assessing, promoting, and enabling of high-quality care at the home.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

● One person spoke positively about how the registered manager had engaged with them, to meet their needs. They said, "I couldn't have done it without [name of manager]."

● People, staff, and relatives were not being involved with the development of the service. There was not a culture of continuous learning and development at the home.

Working in partnership with others

● The registered manager was working with other professionals and a local initiative to meet some people's needs and involve the wider community. A group to promote well-being and create knitted wear for charities was meeting at the home on a weekly basis.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that care and treatment was always provided in a person centred way. Regulation 9 (1) (b) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 HSCA RA Regulations 2014 dignity and respect. The leadership of the service and staff did not always promote people's dignity and respect. Regulation 10 (1) and (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (RA) Regulations 2014: Safe Care and Treatment The provider had not ensured that care and treatment was provided in a safe way. They had not assessed all risks to people's safety or taken appropriate actions to mitigate these risks. Regulation 12 (1) and (2) (a) (b) (d) (g) (h).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 good governance. There was a lack of effective systems to ensure quality care was always provided. Regulation 17 (1) and (2) (a) (b) (c) (e)

The enforcement action we took:

Notice issued to restrict admissions and request action was taken to correct the providers quality monitoring systems. This includes a monthly report evidencing the actions the provider has taken to make these improvements.