Care Homes UK Ltd

Victoria House

Inspection report

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Tel: 01226727179

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 18 February 2016 and was announced. At the last inspection in January 2015 we found the provider was in breach of two regulations, relating to dignity and respect and good governance. We saw the provider had addressed the areas of concern identified at the last inspection.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The home was friendly and welcoming and people, staff and visitors reported a homely atmosphere.

Staffing levels were appropriate to meet people's needs and secure recruitment procedures ensured staff were suitable to work with vulnerable people.

Medications were not always given to people as prescribed and there were some errors in accounting for medication.

Staff understood the Mental Capacity Act and the implications for their work in ensuring people's rights were promoted.

Staff were motivated and dedicated to their work with people. Staff were supported to carry out their work and they had opportunities for regular training and supervision.

People were central to the work and staff were passionate about caring for them. There was evidence of a good rapport with people and their families.

People's dignity and respect were maintained at all times in their care and routine.

The activities coordinator knew people's social histories and engaged with people on an individual basis or in group activities according to their needs.

Care records contained accurate information and regular reviews of care were evident.

People and their relatives knew how to raise a complaint if they felt this was necessary.

The registered manager was visible in the service and knew each person well. People, staff and relatives and visiting professionals said the home was well run and managed.

Systems were in place to monitor the quality of the provision and drive improvement.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed effectively to meet people's needs.

Staff understood individual risks to people.

Safeguarding procedures were in place although not always followed.

Is the service effective?

Good

The service was effective

Staff had many opportunities to undertake training and development to enhance their role.

People's rights were protected in relation to the Mental Capacity Act legislation.

People's dietary and nutritional needs were met.

Is the service caring?

Good

The service was caring

Staff were passionate about their work with people.

People were treated with kindness, compassion, dignity and respect.

The environment was homely and welcoming.

Is the service responsive?

Good

The service was responsive

People received care that was person centred and inclusive of their needs.

Activities were meaningful and staff engaged well with people.

People understood the complaints procedure.

Is the service well-led?

Good

The service was not always well led

There was an open and transparent culture in the home.

Audits were in place although not robust enough to ensure medication was effectively managed.

The registered manager worked closely in partnership with other professionals to ensure people's needs were met.

Victoria House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 18 February 2016 and was unannounced.

There were two adult social care inspectors.

We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with the local authority and contracts team prior to the inspection and spoke with three visiting professionals following the inspection. We observed practice in the home, spoke with the registered manager people, staff and visitors and looked at records to show how the home was run and how people's need were met.

We looked at four care plans, staff duty rosters, three recruitment files and records relating to the safety of the premises and equipment.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. One person said: "I'm safe, sound, secure, what more can I say?". Another person said: "Oh it's all very safe, they [the staff] make sure of that". Another said: "I'm not afraid of anything in here". Relatives we spoke with gave praise for the way in which staff kept people safe. One relative told us: "I have complete peace of mind knowing that [my family member] is here, safe in their care".

Care staff we spoke with were aware of how to detect signs of abuse and knew, if they had any concerns, how to make referrals to the local authority safeguarding team and the Care Quality Commission (CQC). They were aware of the whistleblowing policy and felt any concerns they raised with the manager would be taken seriously. One member of care staff we spoke with had a good knowledge of safeguarding and whistleblowing and could adequately describe their responsibilities in protecting vulnerable people. One new member of staff was confident about the safeguarding procedure and said this had been explained as part of their induction.

Accidents and incidents were recorded and analysed to identify if any trends or patterns existed. The registered manager told us they maintained oversight of these and people's individual risk assessments were updated accordingly, with help from other professionals sought where necessary. We saw a record of an incident in which a person had made an allegation about staff. The registered manager told us this was a common occurrence and the allegation was untrue, with details that the person made false allegations recorded on their care plan. However, this incident was not referred to safeguarding in line with safeguarding procedures. The registered manager confirmed to us the following day this had been referred immediately following the inspection.

Staff encouraged people to be independent and mindful of their own safety. They reminded people to use their walking aids where necessary and encouraged people to move at their own pace to minimise is the risk of falling.

Staffing levels were appropriate to meet people's needs. We saw some staff worked long shifts and the staff rota confirmed staff worked extra shifts at times. We discussed this with the registered manager who gave assurances that they monitored staff to ensure they did not become too tired to manage people's care safely. Staff told us they were happy to cover for colleagues' absences to ensure consistency of care for people.

People's care plans included any necessary risk assessments based both on actual risk and perceived risk. The identified areas of risk depended on the individual and included areas such as skin integrity, mobility and health needs. Staff used recognised assessment tools for looking at areas such as nutrition and tissue integrity. For example we saw how one person had been found to be at potential risk of tissue damage. The assessment had looked at predisposing factors such as diabetes and we saw where risks had been found, risk reduction strategies had been identified. Care plans showed nursing staff had identified the need for the person to sleep on a pressure-relieving mattress. We saw the mattress was in place and inflated to the correct pressure. We also saw evidence of risk assessments which demonstrated little or no risk at the point

of admission with monthly reviews showing increasing risk over time. This demonstrated the provider had established an initial health status for people and was able to monitor health needs over time.

Generic risk assessments were completed for areas such as fire safety and infection control.
We completed a tour of the premises as part of our inspection. The home was constructed on two levels. We inspected five bedrooms and various communal living spaces. All radiators in the home were covered, or were of a cool panel design, to protect vulnerable people from the risk of injury. We saw fire-fighting equipment was available and emergency lighting was in place. During our inspection we found all fire escapes were kept clear of obstructions. We found all floor coverings were appropriate to the environment in which they were used. All floor coverings were of good quality and properly fitted, ensuring no trip hazards existed. Hot water taps were controlled by thermostatic valves (TMVs) protecting people from the risk of scalds. Maintenance records showed TMVs were subject to regular checks and recalibration. However during our inspection we measured the temperature of the hot water supply to one bath to find the temperature in excess of the upper limit of the thermometer and significantly above 43C. We brought this to the immediate attention of the manager who arranged for recalibration. We later re-checked the temperature and found it within the permitted range.

We reviewed environmental risk assessments, fire safety records and maintenance certificates for the premises and found them to be compliant and within date. We saw that Control of Substances Hazardous to Health Regulations 2002 (COSHH) assessments had taken place to prevent or control exposure to hazardous substances. All cleaning materials and disinfectants were kept in a locked room out of the reach of vulnerable people.

During our inspection we looked at how medication administration records and information in care notes for people living in the home supported the safe handling of their medicines. No people at the home were administering their own medicines.

We looked at people's medicine administration record (MAR) and reviewed records for the receipt, administration and disposal of medicines and conducted a sample audit of medicines to account for them. We found some records were incomplete and our audit concluded one person had not received the medication they had been prescribed despite a signature indicating they had.

We found people's medicines were available at the home to administer when they needed them.
We asked a registered nurse about the safe handling of medicines to ensure people received the correct medication at the correct time. Answers given demonstrated they had a good understanding of their responsibilities yet this was not being translated into safe practice.

We observed on six occasions people were not being administered their medicines as directed by the prescriber. Some medicines are required to be given either before or after food yet we witnessed medicines that were to be given 30 to 60 minutes before food being administered either after or whilst people ate their breakfast. For example, one person was prescribed Perindopril 4mgs daily with the label stating 'to be taken before food'. We witnessed this medicine being administered after food. We witnessed other occasions where people were administered their medicines after food rather than as prescribed before food. However on these occasions we saw people who were able to make their own decisions had specifically said they wished to take their medicines after breakfast.

Most medication was administered via a monitored dosage system supplied directly from a pharmacy. This meant the medicines for each person for each time of day had been dispensed by the pharmacist into individual trays in separate compartments. The staff maintained records for medication which was not

taken and the reasons why, for example, if the person had refused to take it, or had dropped it on the floor.

We looked at medication charts and reviewed records for the receipt, administration and disposal of medicines. We conducted a sample audit of medicines to check their quantity. We found records were incomplete and some people had not received the medication they had been prescribed. For example, one person had been prescribed Finasteride 5mgs daily. Records showed the medicine had been dispensed on 1 February with 28 tablets received. Signatures on the MAR sheet indicated 18 tablets had been administered yet 11 tablets remained. Discussion with the registered nurse and the manager came to the conclusion that one day the person had not been administered their medicine. On another occasion we found one person who was prescribed warfarin on a variable dose may not have had the medicine as prescribed. A stock count showed the stock level should be 25 tablets yet our audit found only 24. The registered manager could establish no reason for this discrepancy.

The above examples illustrate the provider was in breach of The Health and Social Care Act 2008, (Regulated Activities) Regulations 2014, regulation 12 Safe Care and treatment, as medicines were not always managed safely.

We saw six people had been prescribed a thickening agent to thicken fluids in order to minimise the risk of choking. Whilst all six people had the product individually dispensed we saw all six people using one person's dispensed item. We discussed our observations with the registered manager and nurse who told us they would speak with their pharmacist and remedy the situation.

Arrangements for the administration of PRN (when needed) medicines protected people from the unnecessary use of medicines. We saw records which demonstrated under what circumstances PRN medicines should be given and at what frequency. The registered nurse demonstrated a good understanding of the protocol.

We noted the date of opening was recorded on all liquids, creams and eye drops that were being used and found the dates were within permitted timescales. Creams and ointments were prescribed and dispensed on an individual basis. We saw the drug refrigerator and controlled drugs cupboard provided appropriate storage for the amount and type of items in use. The treatment room was locked when not in use. Drug refrigerator and treatment room temperatures were checked and recorded daily to ensure medicines were being stored at the required temperatures.

We saw a number of practical steps were in place to address the potential risks of cross infection. For example, anti-bacterial gel dispensers were located throughout the home. We observed all staff washed their hands appropriately between tasks and had disposable gloves and aprons to support people with their personal care tasks. One relative we spoke with said: "This place is spotlessly clean, there are no bad odours and [my family member's] room is immaculate, just as they like it to be". Visiting professionals we spoke with following the inspection gave praise for the cleanliness of the home.

Good

Is the service effective?

Our findings

People told us staff were capable of carrying out their work to a good standard. One person said: "They know what they're doing this lot. I'd trust them 100%". Another person said: ""They can do anything, they're brilliant". One relative told us: "I have every faith in the staff's ability to do their job, they are marvellous".

Staff we spoke with told us they felt very supported to undertake relevant training for their role. We saw the training matrix which showed staff received regular up to date relevant training. New staff told us they had a thorough induction and we saw evidence of completed induction in staff files. We discussed with the registered manager how they ensured the suitability of staff. They explained the recruitment procedures and staff files we looked at evidenced staff had been vetted before they commenced work. The registered manager told us staff turnover was low but it was important that when a vacancy arose, the right person was recruited and so robust recruitment procedures were in place. The registered manager explained ongoing supervision was a key element of monitoring practice and we saw the supervisions matrix showed staff received regular supportive meetings with their line manager. Staff told us the registered manager regularly checked their practice through observations and discussion, formally and informally.

The registered manager told us they felt supported by the operations manager, who allowed them the autonomy of managing the home, but was available for guidance and support where necessary.

Throughout our inspection we saw people who used the service were able to express their views and make decisions about their care and support. We saw staff seeking consent to help people with their needs. When people were not able to verbally communicate effectively we saw staff accurately interpreting body language to ensure people's best interests were being met. Our discussions with staff, people using the service and observed documentation showed consent was sought and was appropriately used to deliver care.

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The manager told us three people were either subject to an authorised DoLS or an application had been submitted for a renewal of an expired authorisation. We saw on all three occasions the best interest's assessor had recommended conditions be attached to the authorisation. We saw the conditions were being met. We spoke with the manager to gauge their understanding of current legislation regarding the Mental

Capacity Act 2005. Their answers demonstrated an adequate understanding of the law and how it had to be applied in practice. Where people were subject to DoLS, the relevant person's representatives (RPRs) were seen to have been involved in decision making and involved in the regular reviews of care needs.

Our observations of the environment and other people's care plans suggested the provider utilised a number of methods which may constitute a deprivation of liberty. We looked at one person in particular who had been assessed as lacking in mental capacity to make their own decisions. They had a sensitivity mat at the side of their bed to alert staff if the person was vacating their bed. The bedroom door had an alarm fitted, which if deployed would alert staff to the person vacating their room. The person was receiving full support for their care needs and was under constant supervision. Whilst each element of restrictions may not constitute a deprivation of liberty, it may be the case that accumulation of restrictions being experienced by some people may amount to unauthorised deprivation of their liberty. We judged the provider may be exercising control over people's care and movements. Subsequent discussion with the manager demonstrated they were aware of our findings and were about to commence discussions with the family with an intention to seek authorisation of DoLS from the supervisory body.

We saw from care records some people had appointed attorneys by way of a lasting power of attorney (LPA) or where people lacked mental capacity, had deputies appointed by the Court of Protection. Care plans had details of where attorneys and deputies had been involved in decision making or where reviews of care plans had been undertaken.

We spoke with one member of care staff about the use of restraint. They were able to demonstrate their knowledge and knew the difference between lawful and unlawful restraint practices. We spoke also with the manager about the use of bed-rails. Answers we received demonstrated when people had capacity they were consulted on the use of bed-rails and understood the action was proportionate to the potential harm. Where there was a lack of capacity or the person's capacity fluctuated, family members were consulted where appropriate before bed-rails were used.

We observed the dining experience for people and found this to be positive and sociable. At lunchtime we observed staff sat with people and supported them to eat. Staff were polite, addressed people by their first names and talked to people while supporting them to eat. We saw the lunchtime experience was unhurried yet staff gave appropriate encouragement for people to eat before their food became cold. We observed one person with reduced grip had been provided with adapted cutlery to enable them to eat independently.

We saw nutritional risk assessments were routinely carried out and where appropriate people's weight was monitored on a monthly basis. We spoke with the cook and it was apparent they had a good understanding of people's dietary needs and preferences. The cook told us the registered manager ensured they were kept aware of people's dietary needs especially when clinically indicated, such as when required by people with diabetes or lactose intolerance. The cook confirmed they encouraged people to eat a varied and balanced diet. People we spoke with told us they were happy with the food provided. One person said, "The food is lovely and today I'm having a beer with lunch." Another person said, "The food is marvellous. It's whatever you want and you're never hungry. There's choices on the menu and if you want something else you can have whatever you fancy". We saw the daily menu displayed adjacent to the dining room accurately reflected the food being served.

Records showed arrangements were in place that made sure people's health needs were met. We saw evidence staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. This had included GPs, hospital consultants, speech and language therapists, community nurses, social workers, opticians and podiatrists.

Our tour of the building showed many aspects of a friendly and responsive environment which respected people's privacy and dignity. Some furniture was showing signs of wear and tear, such as armchairs in the lounge areas and the registered manager said they were aware of this. During our last inspection we had found some ground floor toilet and bathroom facilities were not fit for purpose and in particular did not afford people sufficient privacy. We saw significant structural alterations had taken place with the outcome of much improved facilities. We also noted the installation of an induction loop system in the main lounge to help people who were deaf or hard of hearing to pick up sounds more easily and reduce background noise.

Good

Is the service caring?

Our findings

People gave positive comments about feeling cared for. One person said: "This is a grand place. It's the next best thing to being at home is this. Nothing is too much trouble and I feel I am important here". Another person said: "I need this place. Otherwise I couldn't do anything on my own. They [the staff] understand my needs and they're so kind". One relative said staff cared not only for their family member, but for their whole family too, taking into account their individual circumstances and offering support beyond what they had to provide.

We saw the registered manager and all staff had a warm and engaging rapport with people. There was a homely and friendly atmosphere which was commented upon by people, staff and visitors. Staff described working at the home as being 'like one big family'. Relatives we spoke with said; "It's like extensions of family".

Staff spoke passionately about the people they cared for and were clearly dedicated to providing a caring environment. One member of staff told us they treated people in the same way as they would their own relatives. All staff we spoke with said they would be happy for their own relatives to live at Victoria House.

People looked well cared for and they wore suitable clothing. We asked one person if they always had a good supply of clean clothing; they confirmed they did. We asked if the laundry staff ensured all clothing sent for washing was returned, the person said, "I don't think any of my clothing has gone missing." We saw staff took care to ensure people had important items such as their glasses. We looked around the home with a registered nurse whilst conducting the morning medicine round and in doing so inspected some bedrooms. We noted staff always knocked on doors prior to entering, respecting people's need for privacy. We saw people had been able to make choices about the decoration and furnishings in their rooms. Many rooms contained personal treasured items, family photographs and a personal television.

Whilst all people at the home had the support of families and friends our discussion with the manager showed they had a good insight into the requirements to provide people with advocacy where this was deemed appropriate to protect their rights. The manager also demonstrated their understanding of when an Independent Mental Capacity Advocate (IMCA) may be appointed.

The care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. The correct form had been used and was, on all but one occasion, fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the healthcare professional completing the form. We found one form completed whilst the person was in hospital. The form was incomplete giving no reason why the DNACPR was in place. We spoke with the manager who assured us they would follow best practice guidance and arrange for the GP to reassess the person's needs now they resided in a community setting. The care staff we spoke with knew of the DNACPR decisions and were aware these documents must accompany people if they were to be admitted to hospital.

Good

Is the service responsive?

Our findings

People told us they thought the care at the home was responsive to their needs. One person said: "They [the staff] make it feel like they're there just for me, but I know there's others to consider". Another person said: "Staff listen properly and ask me about what I want". Relatives we spoke with told us staff understood their family members' particular needs and care was based around their preferences and individual wishes. Two relatives described feeling 'over the moon' with the quality of person-centred care.

Three people's care plans we looked at indicted care planning commenced prior to admission. We saw relatives had been included where relevant in the initial care planning and staff had access to relevant information to allow them to construct individual care plans suited to people's needs. Care planning used established tools to ensure measures could be used to track people's improvements or declines in health status. Examples included Waterlow scores for pressure sore assessments and the use of pressure-relieving mattresses and cushions.

Care plans recorded what the person could do for themselves and identified areas where the person required support. For instance we saw one person was able to eat unaided by staff but required adapted cutlery. We saw the required cutlery had been provided and we saw it in use. This demonstrated staff were striving to maintain people's independence when possible. The care plans had sufficient detail to ensure staff were able to provide care consistently. We observed records of care plans were consistent with staff practice. Staff were able to easily access any aspect of defined care need through clearly presented files. Each element of the care file was indexed, colour coded and had a reference tab for ease of access.

We spoke with staff about certain elements of people's care. Their answers demonstrated they had a good understand of people's needs and were aware of when changes had recently taken place.

People had opportunities to engage in meaningful activities and staff had a good understanding of their individual personalities and social histories. We saw people were occupied with crosswords, newspapers and conversation. The activities coordinator engaged people in one to one conversations and they demonstrated a good knowledge of the local area which they used to help people remember times gone by. Group games were organised to include everyone who wanted to join in and the activities coordinator involved people in line with their individual capabilities.

Care staff knew the individual needs of the people and how to ensure these were met. For example, we saw one person was easily distracted by other people when eating their meals. We spoke with staff who assisted this person and we were told that distractions sometimes prevented the person from eating. We saw staff assisted the person in a quiet area of the home in order to ensure they ate their meal successfully.

Staff told us they adapted aspects of care according to what they found people liked. For example, we saw people enjoyed a range of fizzy pop as an option to drink. Staff explained they had offered this at a summer fair and found people liked it so much that it became a regular drinks choice.

People told us they knew how to complain and they were confident action would be taken. One person said: " I just have to open my mouth and it gets sorted. I've nothing to complain about but I know if I did it would be dealt with straight away". One person said if they wanted to help make improvements they could suggest this at a residents meeting. For example, they told us they would like a bigger television and more television channels, but were going to raise this as an item for the agenda. Relatives said they had no cause for complaint but found the registered manager and all staff so approachable they would feel confident to raise issues as they arose. The registered manager told us no complaints had been received since the last inspection, but there was a clear procedure in place should a complaint arise. We saw evidence of compliments through thank you cards and notes displayed within the home.

Good

Is the service well-led?

Our findings

People we spoke with said they thought the home was well run and everyone knew who the registered manager was. One person said: "We always see [manager's name] around and about". Another person said: "It's not just the one in charge, it's all of them, they go well together". Relatives said the registered manager was visible and approachable in the service and we saw this was evident throughout the inspection. Visiting professionals we spoke with consistently expressed confidence in the registered manager's abilities to run the home.

The registered manager had been in post for a number of years and as such, had good knowledge and experience of running the home. Staff reported a very open culture and told us morale was good amongst members of the staff team. We saw this was evident in staff interactions with one another and with the manager; there was friendly professional communication and staff appeared to be motivated and animated in their roles.

The registered manager told us they were committed to continuous improvement of the service and had a rolling programme of improvements. Throughout our inspection the manager continued to outwardly display their passion for the service and the importance of safe effective care.

We saw examples of audits carried out which had either confirmed good practice or identified where improvements had to be made. We saw regular audits carried out on bedroom quality with a list of defects found. Our inspection of people's bedrooms found no evidence of defects with every bedroom furnished to a high standard. Many people at the home mobilised with the help of a wheelchair. We saw the manager audited the functionality and safety of every wheelchair each month. The audit showed where repair was required. Our observations showed wheelchairs to be fit for purpose.

Whilst we observed some weakness in the auditing of medications, it was clear the registered manager played a key role in driving forward improvements. At the beginning of our inspection the registered manager was clearly proud of the environmental improvements they had brought about as a consequence of our last visit.

Communication with staff teams was regular through meetings and handovers. Staff understood the vision and values of the service and their individual roles and they were proud of the care they provided. Where audits and inspections previously highlighted areas to improve we saw this had been discussed within the staff team and all staff were encouraged to work together to drive improvement as a team.

Documentation to support the running of the home was in place. The registered manager told us policies and procedures were being improved to be more tailored to the requirements of the service. We saw quality assurance questionnaires had been sent out and the results were being analysed to evaluate the quality of the provision. People, relatives and staff said they felt their views were important.

There was strong evidence of partnership working with other professionals to meet people's needs. We saw

documented visits in people's care records and we spoke with visiting professionals following the inspection. One professional described the service as 'friendly and professional' and said staff took time to ensure people's needs were met.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed safely or effectively.