Serving All Limited

Vauxhall Court Care Home

Inspection report

Vauxhall Court Residential Care Home
Vauxhall House, Freiston Road
Boston
Lincolnshire
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Tel: 01205354911

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Vauxhall Court Care Home is a residential care home providing accommodation and personal care for up to 33 older people living with dementia. All people living at the service are accommodated on the ground floor. There were 24 people living at the service at the time of the inspection.

People's experience of using this service and what we found
People were not always protected from the risk of harm and abuse. Risks associated with peoples care and support had not always been updated when their care needs had changed, or incidents had occurred. Medicines were not always managed safely by suitable trained staff.

Not all staff had received mandatory training in safeguarding. This meant staff were not always able to recognise safeguarding's or effectively report them to the local authority. Despite these concerns people and their relatives told us they felt safe at the service and were cared for by kind friendly staff.

The manager had worked with the provider to improve staffing levels at the service. However, these levels had been achieved by the staff and managers working additional hours. Recruitment is ongoing at the service.

The service was clean with ongoing maintenance. However, not all maintenance had been identified prior to the inspection.

People were not always supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The manager at the service had not received enough support from the provider and we found further training was required in order for the manager to fulfil their role. Governance systems were not effective. Not all audits had been completed or identified issues at the service. The provider did not have oversight of the quality of the service.

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 (published 14 June 2019)

Why we inspected
We received concerns in relation to the safety of people living at the service as well as the governance at the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We found there was a concern with consent to treatment, so we widened the scope of the inspection to

include the key question of effective.

We looked at infection prevention and control measures under the Safe key question. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Vauxhall Court Care Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

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.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Vauxhall Court 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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was completed by two inspectors.

Service and service type
Vauxhall Court Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Vauxhall Court Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was not a registered manager in post. Therefore, the provider was solely 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
We reviewed information we received about the service since the last inspection and sought feedback from the Local Authority. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke to two people about their experience of using the service and two relatives. We spoke with 12 staff including the manager, deputy manager, team leader, senior carers, carers, maintenance person, laundry assistant, housekeeper. We reviewed a range of records, including care plans and risk assessments, medication administration records, staff files, staff rotas, and audits. We spoke with a social worker who supported people at the service as well as the local authority contracting team.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to Requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- Staff lacked the knowledge needed to protect people from the risk of abuse. Several staff were new to their roles and had not received safeguarding training in the last year. Deficiencies in training meant that staff and managers had not always identified incidents of a safeguarding nature.
- The management team had not always recognised when incidents needed reporting to the local authority safeguarding team or to CQC. For example, two people who would not be able to maintain their own safety had managed to leave the building unsupervised. This was not reported prior to CQC prompting the manager to do so. There had also been an altercation between two people at the service which resulted in a broken bone this had gone unreported.

The provider failed to report reportable incidents to the local authority safeguarding team. This is a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Despite our concerns people and their relatives said they felt safe at Vauxhall Court Care Home.
- Prior to the inspection safeguarding training for staff was booked for a date following the inspection. The deputy manager told us that they would look at having a safeguarding conversation with new staff as part of the induction.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks associated with people's care and support had not always been reviewed and updated, leading to staff having out of date guidance on how to support people.
- Staff told us one person's dietary needs had changed. Their care plan and risk assessments did not reflect their current needs. Furthermore, there was no evidence of an updated risk assessment or referral to health professionals to support the change in need.
- When incidents had occurred involving people, timely review of risk assessments had not taken place. Two people had recently left the home unsupervised. Putting them at risk as they were unable to maintain their own safety whilst away from the care home. Although the manager told us of action that had been taken to mitigate the risk this was not recorded in their care records.
- Accidents, incidents and safeguarding concerns were not effectively reviewed by the management team or provider. There was no log of accidents and incidents, which meant themes and trends were not identified or lessons learnt when things went wrong.
- Some people had charts in place to ensure staff were recording when they are repositioning people or their food and fluid intake. However, these were not always completed by staff, meaning there was no

record if the person had received their specific care.
● Not all furniture was secured safely to the walls. For example, some wardrobes could be pulled over leaving people at risk of entrapment. The manager and the maintenance persons said that they would act on this straight away and ordered materials so that the wardrobes could be secured safely.

Using medicines safely
● Medicines were not always managed safely.
● Where people were prescribed 'as needed' medicine, there was a lack of guidance in place for staff to be aware of circumstances when the person's medicine may be required. This meant there was a risk people would not receive their medicines when they needed them.
● Some people at the service required medicines which were subject to enhanced storage and recording requirements. Recording requirements were not always followed which increased the risk of error.

The provider failed to ensure medicines were always managed safely, lessons were not learnt, and risk management was not effective. This placed people at risk of harm. This is a breach of the regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other care plans we reviewed, had not recently been reviewed by the service. However, they did reflect the needs of the person.
● Not all staff who were trained to administer medicines had been assessed in the last year to be competent. Following the inspection, the management team ensured that all medicine trained staff had been assessed as competent.
● The medicines administration records (MARs) for people's regular medicines showed they were administered safely. We found these records to be accurate.
● The manager said that they would look into better was of recording and reviewing accidents incidents and safeguarding's so that lessons could be learnt.

Staffing and recruitment
● Safe recruitment practices were in place, including checking references of suitability and character and completing a Disclosure and Barring Service (DBS) check. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● The manager had made improvements to the way staffing levels were calculated to ensure there were enough staff. Improvements had been made to staffing levels to ensure people got support at busy times of the day. For example, kitchen assistants had been recruited to ensure care staff could concentrate on their caring tasks.

Preventing and controlling infection
● There were areas of the environment which required maintenance. For example, flooring in one of the bedrooms needed replacing. We also found coins had been glued to a windowsill this had been an engaging activity for people at the service. However, this compromised the ability to effectively clean the surface as there was a build-up of dust and debris between the coins. The manager said they would look into ways of covering the coins to ensure hygienic cleaning could be maintained.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● The service facilitated visits in line with the national guidance.

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 MCA 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 , whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- The management team had not always identified where people needed to have mental capacity assessments and decisions made in their best interest. There was a lack of understanding regarding the MCA at the service.
- Where people were restricted by the use of bedrails there was no documentation to state if the decision had been made in the persons best interest or if it was the least restrictive option.
- CCTV was in use within communal areas of the home. However, there was no documentation in people's care records that this had been discussed with them or that a decision had been made in their best interest.

People were not supported with appropriate or specific mental capacity assessments related to their care. This was a breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff support: induction, training, skills and experience
- Staff did not always have the training they needed in order to carry out their responsibilities.
- The management team were new to their roles and did not have effective support or training required for their roles. Following the inspection, the provider said they had organised training for the manager and the

deputy manager. They had also informed us they would organise meetings with managers from other services owned by the provider.
● Staff we spoke with said their induction had not been effective in giving them the skills they needed. One staff member said they had been shown the wrong way to do some tasks. But that the manager made sure when they realised that they were shown the right way.
● Safeguarding although mandatory training, was not part of staff induction. The deputy manager said they would look at getting this added to the induction process.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The manager was able to share with us that they had a good working relationship with the local G.P and the district nursing team. Professionals we spoke with said the service worked well with them and communication was effective.
● Kitchen staff were knowledgeable about people's dietary needs. However, they did not have a record of people who required modified diets. The manager said they were going to ensure they had the relevant information.
● We saw staff supporting people at mealtimes. Staff interacted and communicated well with people to ensure they knew what they were eating.
● We observed one person was not enjoying their food. Staff offered another choice to ensure the persons nutritional needs were met.

Adapting service, design, decoration to meet people's needs
● The service was in the process of being redecorated. Improvements had been made to the environment. People had access to a choice of T.V and radio as well as bed side lamps the manager told us these things had not been available before. Soft furnishings had been up graded.
● These improvements had been made alongside the recruitment of another maintenance person as well as staff decorating in their own time.
● All bedrooms at the service were on the ground floor. There was room at the service for people who walked with purpose to do so safely.
● The service has large secure gardens which the manager told us had recently been improved as had been overgrown. We were informed that residents enjoyed the open space in the warmer weather.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Care records and risk assessments were not always up to date. This meant it was not always clear if assessment's reflected people's current needs and choices.
● Equipment needed to support peoples care such as walking aids and hoists were available. These were in good working order on the day of inspection.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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; Continuous learning and improving care

- The manager and the provider did not have oversight of the service and there was an absence of robust systems to ensure people's care, safety and welfare was continually improved and monitored. Concerns highlighted during our inspection had not been identified relating to risk management, medicines, accidents and incidents, training and safeguarding.
- There was no formal process in place to review and analyse accidents and incidents at the service. This meant learning had been missed and people could continue to be at risk of repeated incidents.
- Quality assurance processes in place were not robust or effective at identifying shortfalls within the service provision. Audits which had been undertaken lacked meaningful content regarding aspects of the service. For example, the medicines audit was only a stock check and did not pick up on issues found during the inspection. Where issues were identified on audits no action plan had been put in place to address these issues.
- The provider had not adapted during the pandemic to support staff with mandatory training when in person training was unavailable. They had not provided staff with online training to support them in understanding their roles in relation to safeguarding. Safeguarding training was booked for a date after the inspection.

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

- The manager was working on making improvements at the service. They had found not all long-standing staff had agreed with the improvements they were making and had left the service. This had resulted in staff turnover.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Most staff spoke highly of the manager and the management team. They said that there was an open-door policy where staff could raise issues if they needed to. Staff told us they felt supported and listened to.
- The manager was accepting of the shortfalls found during the inspection and was actively looking at ways to address issues found. A new medicines audit was put in place to be used following the inspection.

Engaging and involving people using the service, the public and staff, fully considering their equality

characteristics; Working in partnership with others

● The manager informed us that they had not had a team meeting since December as the management team had been needed to cover shifts.

● Relatives had left reviews online stating that improvements had been made over the last year. That they were happy with changes made by the new management team.

● The manager was working closely with the local authority contracting team to improve quality of care at the service.

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

● The manager was open and honest during the inspection. They were working closely with the local authority contracting team to improve quality at the service.

● The manager ensured to contact family when there was an accident or incident. The manager ensured apologies were given when things had gone wrong.

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 18 Registration Regulations 2009 Notifications of other incidents The provider did notify CQC of all notifiable incidents

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were not supported with appropriate or specific mental capacity assessments related to their care.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Peoples care needs and the risks associated with them were not always assessed and reviewed in order to keep them safe. Medicines were not managed safely at the service

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There had been a failure to report all safeguarding incidents to the local authority. At the time of the inspection most staff had not had up to date Safeguarding training.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have oversight of the service. Governance was not effective.

The enforcement action we took:

warning notice