Sun Care Homes Limited

Victoria Cottage Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 13, 14 and 19 January 2016. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to regulations 11, 12, 13, 16, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Victoria Cottage Residential Home on our website at www.cqc.org.uk.

We inspected the service on 19 April 2016. The inspection was unannounced. Victoria Cottage Residential Home is owned and managed by Sun Care Homes Limited. It is registered to provide accommodation for up to 18 older people. On the day of our inspection nine people were using the service.

The service did not have a registered manager in place at the time of our inspection. 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.

We found that although the registered provider had engaged a consultant to drive improvements in the service and had spent money on upgrading the environment, this had not resulted in people being given safe, effective and responsive care and support.

People were still not protected from the risk of harm, due to ineffective systems in place to protect them. Risks in relation to people's daily life were not being assessed or planned for. Staffing levels had not been increased but as there were less people using the service there were enough staff to support people. Medicines were not managed safely and people could not be assured they would receive their medicines as prescribed.

Although more training had been given to staff, people were supported by staff who still did not have the knowledge and skills to provide safe and appropriate care and support. People were supported to make decisions if they had the capacity to do so. However people who did not have the capacity to make certain decisions were not protected by the Mental Capacity Act 2005. People had restrictions placed upon them without the required authorisation to do so and care was not planned to ensure it was delivered in the least restrictive way.

There was a lack of planning and delivery of safe and responsive care and this resulted in people not being cared for appropriately. People felt they could raise concerns if they wished to.

There was still a lack of appropriate governance and risk management framework and this resulted in us finding ongoing breaches in regulation and negative outcomes for some people who used the service. People were not involved in giving their views on how the service was run and there was a lack of effective systems in place to monitor and improve the quality of the service provided.

The overall rating for this service remains 'Inadequate' and the service therefore remains in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

We found that action had been taken to improve some areas of safety but people were still not being protected from harm.

People may not be protected from abuse because the provider had not ensured there were systems in place to protect people from the risk. People were exposed to risks unnecessarily because ways on minimising these were not identified.

People did not always receive their medicines as prescribed and medicines were not managed safely. People lived in an environment which was more clean and hygienic. There were enough staff to provide care and support to people.

Is the service effective?

Inadequate

The service was not effective.

We found that action which had been taken to improve the effectiveness of the service had not resulted in people receiving effective care and support.

People were still supported by staff who were not provided with enough training to enable them to support people safely.

Where people needed support to make decisions they were not protected under the Mental Capacity Act 2005. People received support which was not assessed and planned for to ensure it was delivered in the least restrictive way.

People were not always supported to maintain their nutrition.

Is the service responsive?

Inadequate

The service was not responsive.

We found that action had not been taken to improve the planning and delivery of care people received.

People's care and support was still not planned in a way that showed their needs and how these should be met.

People felt there concerns would be listened to and there were systems in place to deal with concerns raised.

Is the service well-led?

Inadequate

The service was not well led.

We found that action had been taken to improve the way the service was monitored but these had not been effective in improving the quality of care some people were receiving.

People were still not involved in giving their views on how the service was run.

Victoria Cottage Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

We undertook an unannounced focused inspection of Victoria Cottage Residential Home on 19 April 2016. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 13, 14 and 19 January 2016 inspection had been made. The team inspected the service against four of the five questions we ask about services: is the service safe, is the service effective, is the service responsive and is the service well led. This is because the service was not meeting some legal requirements. The inspection team consisted of three inspectors.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and assessing whether statutory notifications had been received. A notification is information about important events which the provider is required to send us by law. We spoke with commissioners who fund the care for some people and looked at feedback received from Nottinghamshire County Council following their recent visit.

During the visit we spoke with four people who used the service and carried out observations in the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with two members of support staff, the acting deputy manager and the registered provider. We looked at the care records of six people who used the service, medicines records, staff training records, as well as a range of records relating to the running of the service.

Inadequate

Is the service safe?

Our findings

The last time we inspected the service we found there were improvements needed in relation to people being supported by insufficient numbers of staff, keeping people safe from harm, the safe management of medicines and the environment people lived in. During this inspection we found some improvements had been made but that further improvements were needed.

Although people we spoke with told us they felt safe, people could not rely that systems in place would protect them from harm. Just prior to our inspection the manager had notified us of three incidents which had happened recently in the service when a person who used the service who sometimes communicated through their behaviour had hit other people who used the service.

We looked at this person's care records and saw they needed support from staff due to outbursts of behaviour which staff may find challenging to deal with. We saw that the manager had sought advice from external professionals and that the person was being given extra support from staff during the afternoon and evening. However systems were not in place to attempt to support this person with their behaviour and reduce the risk to themselves and others.

There was some information recorded in the person's care records from external professionals but a care plan had not been devised informing staff what might trigger the person's behaviour, how to avoid the triggers and how to respond if the behaviour escalated. It was known that a health condition was a contributing factor to this person's behaviour but this health condition was not being monitored effectively so that staff would know when to seek support from the person's GP. Staff were recording incidents of when the person communicated their behaviour but there was no learning from this so that future incidents could be avoided to keep people from the risk of harm from this person. We observed this person for a six and a half hour period and they were left in their wheelchair at a dining room table alone and facing a blank wall. This could have an impact on their behaviour and we saw they were starting to get agitated after lunch and trying to push themselves away from the table. When the staff member arrived in the afternoon to give the person their extra support we saw the person's demeanour changed significantly, the person was stimulated, engaged and smiling.

This was an ongoing breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found medicines were still not being managed safely and there was a risk people would not receive their medicines as prescribed. Staff were still not following safe protocols when they administered medicines and we found a number of issues. For example we saw that staff signed people's Medication Administration Record (MAR) to state the medicines had been taken prior to actually administering them. There was a high number of times when staff had handwritten medicines on people's medicines administration records (MAR) and the entries were not being checked by a second member of staff to ensure the entry was accurate. This gave the potential for the entry to be incorrect and people being given the wrong medicines.

Staff who were administering medicines were still not having their competency assessed, to ensure they knew how to safely administer and manage medicines. There had been a medicines audit completed since our last inspection but despite this we still found issues with the medicines management and this included discrepancies with controlled drugs. Controlled drugs are sometimes misused and so they have stricter legal controls on their storage and administration procedures.

We saw that risks in relation to people's care and support were still not being assessed and planned for safely. For example two people who had been assessed as being at high risk of developing pressure ulcers were not supported with the risks in relation to this. External healthcare professionals had recommended both people should have been given support to reposition one to two hourly during the day but we saw one was left sat in a wheelchair for over six hours without moving and the other person was left for over five hours. Neither of these people had a care plan in place which detailed the instructions given by the healthcare professionals nor neither were being supported to reposition in line with the recommendation. One of these people currently had a pressure ulcer and there was a risk this would deteriorate or the person would get a further pressure ulcer without the recommendations being followed.

This was an ongoing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found there had been improvements made to the environment and to infection control systems. The registered provider had engaged a company to carry out a 'deep clean' of the service and there had been some carpets replaced. We saw this resulted in people living in a cleaner and safer environment. Some of the improvements to the environment were still in progress but the provider told us they were committed to finishing the improvements.

We carried out a tour of all bedrooms, communal areas including bathrooms and toilets and the laundry. We found the service was cleaner than it had been when we last inspected and new bathrooms were in the process of being installed. We saw laundry trolleys had been purchased to prevent soiled laundry from being stored on the floor.

We saw there were improvements needed in relation to sustaining the cleanliness of the environment. There was still only one housekeeper working in the service over three or four days a week and the rest of the time care staff were undertaking the cleaning. Care staff were not always completing the cleaning schedules and so there was a risk some cleaning may not be completed. The acting deputy manager told us a second cleaner had been employed and would commence working in the service at the end of the month.

We found that although staffing levels had not increased, the number of people living in the service had decreased and on the day of the visit we observed there were sufficient numbers of staff available to support to people. People felt there were enough staff to support them. One person told us, "The staff are always there if I need them." Another person told us, "People look out for you, you are never alone."

The acting deputy manager told us they aimed to have three care staff on duty during the day and two at night and the rota's we saw reflected this was the case. Although the numbers of the day time staff sometimes fell to two, staff we spoke with told us they felt there were enough staff to meet the needs of the people who were living in the service.

Inadequate

Is the service effective?

Our findings

The last time we inspected the service we found there were improvements needed in relation to people being supported by inadequately trained staff, people being supported with nutrition and healthcare and the protection of people under the Mental Capacity Act (MCA) 2005. During this inspection we found some improvements had been made, but that further improvements were needed with nutirtion.

People received care and support from staff who still did not all have the skills and qualifications to support them safely. The acting deputy manager told us that since our last inspection staff had completed training in areas such as infection control and food hygiene. However there were a number of staff who had not completed training in the MCA and DoLS and staff had not been given any training on how to support a person who had a health need which staff were responsible for monitoring.

We observed staff supporting a person to transfer using equipment and we saw they followed safe practice whilst doing this. We saw staff had received training in how to do this since we last inspected. People were supported by staff who were having their working practice or training needs assessed. Staff were now being given supervision to discuss their development needs.

One member of staff described work they were undertaking in relation to the care certificate. The care certificate is a recently introduced nationally recognised qualification designed to provide health and social care staff with the knowledge and skills they need to provide safe, effective 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 and hospitals 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.

We found people were still not protected under the MCA. In the care records of one person we saw there was still conflicting information about the person's capacity to make decisions. There was a record in the person's care plan which stated they could not communicate verbally, which staff confirmed to be the case. However there was a communication plan in place which stated the person could communicate their needs and wishes verbally.

We saw staff had recorded that another person was living with a dementia related illness and was unable to make decisions about their medicines. However a MCA assessment had not been carried out to ensure

decisions about the person's medicines were in their best interest and this person was given medicine to try and stabilise the way they communicated through their behaviour.

Another person had a new specialised 'tilt chair' and the acting deputy manager told us the person was a high risk in relation to falls and the chair was in place to keep them safe and stop them from getting up out of the chair. This person lacked capacity to understand this decision but a MCA assessment had not been completed to show this decision was in their best interests.

Staff we spoke with did not have a good understanding of the MCA and we saw that most staff had not received recent training or guidance in the MCA and how they should support people with decision making.

This was an ongoing breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were still not protected from the risk of being supported in the least restrictive way. The last time we inspected the service there were two people who resisted personal care and staff told us they were using passive restraint on these people without a DoLS being in place. We found this had not changed when we visited on 19 April 2016 and the restraint was still being used without any DoLS or planning in place detailing how staff should support these two people, when they resisted personal care, using the least restrictive methods. We observed staff trying to get one of these people to use a hoist to transfer into an armchair and the person resisted.It was clear staff did not know how to deal with this and made comments including, "Stop kicking and "[person's] got it right on them today." They then left the person stating they would come back in five minutes, but they did not do so. We saw the person was left in their wheelchair for over three hours until the deputy manager came and helped them move to an armchair.

This was an ongoing breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that some improvements had been made in relation to supporting people with their nutrition. People told us they enjoyed the food they were given. One person told us, "It is very nice." When we asked if they were enjoying their meal. People's nutritional needs had been assessed and we saw that two people had been noted as losing weight and both were having their food intake monitored to assess how much they were eating.

However we saw one person had their nutrition assessed recently and staff had recorded the person was refusing meals which was causing weight loss and staff should support the person to eat. This information had not been transferred onto the person's nutritional care plan and we observed on the day we visited the person was sat alone throughout the lunch time period. Staff did not provide them with any support to eat their meal other than stating "Eat your lunch" on a few occassions. We observed at lunchtime the person did not eat their main meal and staff replaced it with a dessert. The person ate all of the dessert and asked for more but staff told them there was not any left. We saw there was plenty of this dessert in the pantry which the person could have been given.

Inadequate

Is the service responsive?

Our findings

The last time we inspected the service we found there were improvements needed in relation to people having their support needs assessed and planned for to ensure they were cared for safely and in how complaints were responded to. During this inspection we found that improvements had not been made and people were still at risk of their needs not being met due to poor planning of their care. There had not been any complaints recorded since our last inspection so we were unable to assess if improvements had been made in how complaints were responded to.

We found issues with the same care plans that we had concerns about when we inspected in January 2016. The care plans had not been updated to include people's current needs and to provide staff with the information they needed to support people safely. For example, One person had a medical need and the last time we visited we were concerned their care plan stated they managed this themselves when in fact staff were supporting them, without any guidance or training in how to do this safely. This time when we visited, the care plan had still not been updated and staff were managing this without the skills and knowledge to do so. This left the person at risk of developing an infection.The person had developed an infection the month prior to our visit which had led to them being admitted to hospital, and was still unwell.

The last time we visited we saw in the care records of two people that they were at high risk of developing a pressure ulcer and there were recommendations from visiting health professionals for staff to follow to minimise the risk of this happening. This information had not been transferred into the two care plans and staff were not taking steps to minimise the risk, such as supporting both people to change their position during the day and night. When we visited this time we found this had not changed and these people were being placed at risk of developing a pressure ulcer.

Another person had been assessed by external professionals in relation to their mobility and they had recommended regular chair exercises be done with the person to try and increase their mobility. This had not been added to their care plan the last time we visited and the person was not being regularly supported to do the exercises. This time when we visited, the information had still not been added to their care plan and not all staff were aware of the need for the exercises and there were no records to show the person was being supported with this.

We observed people were not getting support with their continence needs. We observed three people from 9.30am until 4pm, all of whom who required support from staff to go to the toilet. These three people were not asked if they would like to go to the toilet, or supported to go to the toilet during the six and half hour period. We saw staff were available to give this support but it was not offered. Two of these people had information in their care plan which instructed staff to prompt them to go to the toilet regularly.

Care plans still held contradictory information. For example, one person had a document in place stating they were at risk of falls, however their care plan stated they were not at risk of falls. Care plans were still not being updated when people's needs changed. For example staff sat with one person and fed them their

meal at lunchtime but their care plan stated they did not require assistance to eat.

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

People told us they were happy living in the service. One person told us, "They (staff) bend over backwards for us. Another told us, "Staff are ever so kind."

There was still a lack of opportunity for people to follow their hobbies and interest where they needed support to do so. Although some activities were taking place, such as on the day of our visit we saw that three people were supported to have a game of dominoes in the afternoon, the opportunities were still limited. One person said they kept themselves occupied and felt they had enough to do but could not remember any activities being offered. Another person could not describe any activities which took place in the service. One person we spoke with said they were happy not to take part in activities and preferred to spend time alone. We saw some people spent the duration of our visit with no activity or stimulation provided.

The provider sent us an activities plan but at the time of our inspection records were not being kept to show if the activities had taken place or who had taken part. Following our inspection we were sent newly implemented records showing people taking part in some activities after our inspection, however there was still a lack of forward thinking on how to plan activities around people's preferred hobbies and interests.

Although there wasn't a complaints procedure on display, people told us they felt they could raise concerns if they wished to. One person told us, "I know very well that if I had a problem I would just tell someone, anyone. If they didn't know then I would just ask someone else."

The acting deputy manager told us there had not been any complaints since we inspected the service in January 2016 and so we were unable to assess if the service responded to concerns appropriately. However there was a complaints procedure in the office and staff were aware of the need to record and act on concerns raised.

Inadequate

Is the service well-led?

Our findings

The last time we inspected the service we found there were improvements needed in relation to the provider's lack of effective systems in place to monitor the quality and safety of the service. The lack of effective systems had led to negative outcomes for some people who used the service. During this inspection we found some improvements had been made but the improvements had not led to people receiving safe, effective and responsive care. There was still a lack of appropriate governance and risk management framework and this resulted in us finding multiple ongoing breaches in regulation and negative outcomes for people who used the service. There were no effective systems in place to develop and improve the service, based on the needs of the people who used it.

The culture within the service did not encourage suggestions and ideas on how to improve the service. People had few opportunities to contribute to making improvements or changes to the service. None of the four people we spoke with knew who was in charge of the service and there was still a lack of meetings held for people to attend and give their views.

There has not been a registered manager in post since 2010. The acting manager who was in post the last time we visited was no longer working in the service and there was a new acting manager in post. The acting manager was not on duty on the day we visited and we were assisted by the acting deputy manager. A condition of the registration is that there should be a registered manager in post. We have discussed this with the provider and will monitor this.

The registered provider had engaged a consultant to make improvements in the service and to implement an effective monitoring system to identify and bring about the improvements. However we found that many aspects of improvements we had asked for had not been addressed. The consultant, acting on behalf of the registered provider, sent us an updated action plan on 5 April 2016 and detailed what actions had already been addressed. One of these actions was to ensure individual comprehensive care plans are present for each person using the service and this would be complete by 31 March 2016. When visited on 19 April 2016 we found this action had not been completed and the care plans remained the same, in that they did not meet the needs of the people who used the service and give staff the information they needed to ensure they knew how to support people safely.

Other examples of the action plan not being met were that the action plan stated that by 23 March 2016 MCA assessments would be in place for people who lacked the capacity to make certain decisions and that DoLS referrals would be made where needed. The action plan stated that behavioural care plans would be written for people who displayed behaviour that staff may find challenging by 23 March 2016. When we visited on 19 April 2016 we found this none of these actions had been completed. This showed that the registered provider was not making the improvements they told us they would and did not provide us with assurances that the improvements would be made.

There was a lack of effective auditing systems in place for identifying and improving the quality of the service and this had led to people receiving care which was inconsistent and had not met their needs. The audits

had not picked up issues that are identified in this report in areas such as the risks relating to a lack of effective care planning, people not having their needs met and receiving unsafe care. This showed the systems in place were still ineffective in identifying where improvements were needed. Had effective systems been in place these issues which placed people at risk of harm could have been identified and acted on prior to us visiting.

Records showed that infection control audits were now being undertaken. However there was no action plan from the last audit carried out. The report stated that equipment used in the service needed to be added to the cleaning schedule but this had not been done. Food hygiene audits had also been implemented. However the last audit recommended colour coded knives were purchased and this had not been done. This showed that the audits were not effective in bringing about improvements when issues were identified.

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

Staff told us they now had the opportunity to attend regular meetings where they could give their opinions of how the service could improve. They told us they felt more supported than they had in the past and that they were listened to. However on the day of the inspection we did not see effective leadership which led to people receiving care and support when they should. There was an acting deputy manager and a senior care worker on duty but neither challenged care staff about why two people were left in wheelchairs for in excess of five hours and neither directed staff to ensure people were supported to go to the toilet during our six and half hour observation.

We saw the provider kept compliments logs and there had been one compliment from a relative since our last inspection in January 2016. The relative had said, 'Nothing is too much trouble. Definitely go the extra mile."