Dukeries Healthcare Limited

Victoria Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 11 and 12 December 2017. Victoria Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single packages under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Victoria Care Home accommodates up to 93 people in two buildings, divided into four units. The Camelot unit provides residential care. Lancelot unit provides residential care to people living with dementia. Guinevere unit provides nursing care. Champion Crescent and Flats provide support for people with an alcohol related brain injury. During our inspection, 76 people were using the service.

There was no registered manager in post at the time of our inspection; the previous registered manager had left the service in September 2017. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. An interim manager had been in post since September 2017 and they were in the process of applying to register with the CQC.

At the last comprehensive inspection of this service on 20 December 2016, we asked the provider to take action to make improvements to the governance of the service. Sufficient improvments were not made and during this inspection we found multiple breaches of the Health and Social Care Act 2008 regulations. You can see what action we told the provider to take at the back of the full version of this report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

People were at risk of unnecessary harm. Systems in place to protect people from the risk of abuse or improper treatment were not effective. People were not always protected from risks associated with the premises or the improper use of equipment. People were not always protected from risks associated with their care and support. People were not always supported by sufficient amounts of staff and staff were not always recruited safely. People could not be assured that the management of medicines was safe and that equipment used was clean.

People's rights under the MCA were not always protected as the Act had not always been applied to ensure that decisions were made in people's best interests. People could not be assured that staff had the skills and training they needed to meet people's needs in an appropriate way. People did not always get the support they required to eat their meal in a safe way and records did not show that people were always supported to drink a sufficient amount. People had access to health professionals, however, information in care plans about the support people required to maintain good health was not always clear. Although the premises had been adapted to the needs of people living there, improvements were required to ensure that equipment and safety measures were used appropriately.

People told us that most of the staff at Victoria Care Home were caring although some staff did not always

display a caring attitude. Our observations supported what people had told us. People's privacy and dignity was not always respected. People had access to advocacy services.

People were at risk of receiving inconsistent support which was not always personalised to their needs. People's care plans contained limited information about how staff should support them in line with their preferences at the end of their life. People were supported to take part in some activities and social opportunities although at other times people were provided with little stimulation. Improvements were required to ensure that people's concerns and complaints were captured and responded to appropriately.

The service was not well led. Systems in place to monitor and improve the quality and safety of the service were not effective and this placed people at risk of harm. Some areas of service provision were not robustly monitored and effective action was not always taken in response to issues identified. People were provided with opportunities to provide feedback on the service they received but these were limited and did not capture the concerns identified during this inspection. Staff felt motivated by the manager of the service and felt that improvements were being made.

The overall rating for this service is 'Inadequate' and the service is therefore in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not fully protected from the risk of abuse or unnecessary harm.

People were not always protected from risks associated with the premises or the improper use of equipment.

People were not always protected from risks associated with their care and support.

People were not always supported by sufficient amounts of staff and staff were not always recruited safely.

People could not be assured that the management of medicines was safe and that equipment used was clean.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights under the MCA were not always protected as the Act had not always been applied to ensure that decisions were made in people's best interests.

People could not be assured that staff had the skills and training they needed to meet people's needs in an appropriate way.

People did not always get the support they required to eat their meal in a safe way and records did not show that people were always supported to drink a sufficient amount.

People had access to health professionals, however, information in care plans about the support people required to maintain good health was not always clear.

Although the premises had been adapted to the needs of people living there, improvements were required to ensure that equipment and safety measures were used appropriately.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us that most of the staff at Victoria Care Home were caring although some staff did not always display a caring attitude.

People's privacy and dignity were not always respected.

People had access to advocacy services.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were at risk of receiving inconsistent support which was not always personalised to their needs.

People's care plans contained limited information about how staff should support them in line with their preferences at the end of their life.

People were supported to take part in activities and social opportunities although at other times people were provided with little stimulation.

People could not be assured that concerns and complaints were captured and responded to appropriately.

Is the service well-led?

Inadequate

The service was not well led.

Systems in place to monitor and improve the quality and safety of the service were not effective and this placed people at risk of serious harm.

Some areas of service provision were not robustly monitored and effective action was not always taken in response to issues.

People were provided with opportunities to provide feedback on the service they received but these were limited and did not capture the concerns identified during this inspection.

Staff felt motivated by the manager of the service and felt that improvements were being made.

Victoria Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 11 and 12 December 2017 and was unannounced. The inspection team consisted of two inspectors, a specialist advisor who was a nurse and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. The inspection was also informed by other information we had received from and about the service. This included previous inspection reports and statutory notifications. A notification is information about important events which the provider is required to send us by law. We also sought feedback from the local authority, who commission services from the provider.

During the inspection, we spoke with 18 people who lived at the service and 17 relatives or friends who were visiting. We spoke with two unit managers, four senior care workers, an activities co-ordinator, two housekeepers, the chef, maintenance person, the manager and compliance manager. We also spoke with two healthcare professionals who routinely visited the service.

We looked at all or part of the care records of nine people who used the service, medicines administration records, staff training records and the recruitment records of three members of staff. We also looked at a range of records relating to the running of the service, such as audits and maintenance records.

We observed care and support in communal areas of the service and 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.

Inadequate

Is the service safe?

Our findings

People expressed mixed views as to whether they felt safe living at the service. Whilst some people told us the building was secure and staff kept them safe, other people expressed the opposite view. One person commented, "I just feel safe. I feel like it's my home and the residents are my family. The staff are lovely." Another person told us, "I feel safe but not comfortable. I don't think the building is secure."

People could not be assured that staff had the necessary knowledge and training to keep them safe from abuse. The staff we spoke with told us they had received training in safeguarding adults from abuse. However, it was not possible to establish whether all staff had received appropriate training due to staff training records being incomplete. The staff we spoke with displayed a limited knowledge of the different types of abuse and the signs and symptoms they would look for which could indicate abuse. This meant that staff may not recognise potential abuse and act appropriately to keep people safe.

Action had not always been taken to ensure people were protected from the risk of abuse. Records showed occasions when some people had unexplained bruising. The bruising had not been investigated by the provider and referrals had not been made to the local authority safeguarding team. An investigation may have determined how the bruising had occurred or identified any trends of when people had sustained bruising. Referrals would have enabled the local authority safeguarding team to determine whether any further action was required to keep people safe. We made a safeguarding referral on behalf of one person following our inspection.

People could not be assured that referrals were always made to the local authority safeguarding team when required. Records showed that an altercation had occurred between two people who lived at the service. This incident had not been referred to the local authority safeguarding team.

We wrote to the provider and asked them to take urgent action to ensure people were protected from the risk of harm. On 15 December 2017 the provider advised us that improvements would be made to their system for investigating incidents, including unexplained bruising and that staff would receive training in safeguarding adults. We will check the impact of this at our next inspection.

The above information was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from risks associated with the premises or the improper use of equipment. During our inspection we found that not all of the windows were secured to ensure that the risk of people falling or leaving the service through a window were reduced. The local authority safeguarding team made us aware of recommendations they had made in May 2017 following an incident whereby a vulnerable person had left the service during the night through a window in a communal area of the service. Despite a recommendation being made to ensure that communal windows were secure, we found that two windows in communal areas of the service were not secured and could be opened fully. In one part of the service the risk of a person either falling from or leaving the service through a window had not been

considered and no safety measures were in place. This placed people at risk of unnecessary harm. We wrote to the provider and asked them to take urgent action in relation to this. They told us that, following our inspection, all windows had been checked in all areas of the service and that these were secure and that new window restrictors had been sourced.

Records showed that checks to ensure people were protected from the risk of legionella bacteria were insufficient. This was because they did not show that the required checks were carried out in all areas of the service on a regular basis to reduce the risk of bacteria growth. This posed a risk of harm to people from Legionnaires disease. We wrote to the provider and asked them to take urgent action in relation to this. The provider told us what action they would take to fully assess and mitigate the risk to people from legionella. We will check the impact of this at our next inspection.

In addition, we identified that equipment was not always being used safely. For example, we observed that pressure relieving mattresses were not always used at the correct setting for people and that a fire door was propped open with equipment which might prevent it closing in the event of a fire. The provider removed the equipment which was propping open the fire door and told us that checks on pressure relieving equipment would be carried out regularly throughout the day by care staff and weekly by the management team to ensure it was at the correct setting the person.

People were not always protected from risks associated with their care and support. For example, one person's care records stated they required a soft fork mashable diet to reduce the risk of them choking. During our inspection we observed the person was served a meal which consisted of chunks of meat. The meat had not been mashed and we observed the person coughing whilst eating their meal. In addition, we observed another person coughing whilst eating their meal. A staff member identified the person was struggling to eat their meal and sought an appropriate alternative meal. However, the person continued to cough and although staff members were present they either did not notice or respond to check the person was safe and well. This meant that people were at risk of choking.

Records showed that people who lived at the service had risk assessments in relation to different areas of their care such as nutritional risk and risk of developing a pressure ulcer. We found that the measures required to reduce the risk of harm to people were not always clear in care records. For example, one person's care plan contained contradictory information about how often they required support to re-position to reduce the risk of skin breakdown. In one section of the care plan it stated they required support to re-position every two hours, it another part it stated every four hours. In addition we found that care records did not assure us that people were receiving appropriate support to reduce risks. For example, according to records one person who required regular repositioning had not changed their position for seven hours. Another person was at risk of frequent urinary tract infections and their daily records did not show they were being supported to drink the amount they required to reduce the risk, as outlined in their care plan. The provider told us they would implement a system to ensure that daily care records were checked daily.

People were at risk of not receiving the medicines they required. The first day of our inspection was the first day of the new medicines cycle and a member of staff informed us that medicines were not checked until the night before. This meant it was not possible to correct issues with the non-supply of two people's medicines until the first day of the cycle. Consequently two people missed their medicines or had them late during our inspection. We found additional gaps in the administration of four people's medicines due to them running out and not being replaced in a timely manner. This meant that people did not always receive their medicines as prescribed. In addition, staff had, on four occasions, made a decision to omit medicines for 'clinical reasons' however, the actual reason was not recorded. This meant that the reasons for

medicines not being given could not be effectively monitored and that people may not receive medicines as required.

Medicines were not always stored safely. The lock on one medicines trolley was broken but the trolley continued to be used. This poses a risk of unauthorised access to medicines. Records showed that a stock check of controlled drugs was carried out monthly. NICE guidance dated 12 April 2016: 'Controlled drugs: safe use and management' states for most organisations stock checks should be at least once a week. Monthly checks pose a risk that it would be difficult to identify any discrepancies as it would be unclear when the issue occurred. In addition, liquid medicines and topical creams were not always labelled with the date of opening. This poses a risk that medicines would be used after the recommended timeframe. Furthermore, a patient safety alert had been issued by NHS England in February 2015 regarding the potential risk to people from ingestion of fluid thickening powder. We found that fluid thickening powder was stored inappropriately in a container in the person's bedroom. We wrote to the provider and asked them to take urgent action in relation to these issues. The provider told us they had made changes to their system for ordering people's medicines, and would complete a medicines audit and review staff competency. We will check the impact of this at our next inspection.

The failure to assess the risks to health and safety of people and mitigate risks as much as possible constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People expressed mixed opinions on whether the service was clean and hygienic. One person told us "I have not had my room cleaned since Friday (three days prior to our inspection) and the bin is full," whilst a relative told us the kitchen area attached to a dining room was not clean. Whilst the areas of the service we saw appeared clean, we found that some people's wheelchairs were very encrusted with food. This was despite checks having been completed by staff stating that wheelchairs had been cleaned. In addition, an infection control audit had been carried out by an external agency prior to our visit. The agency found that some pressure relieving mattresses had been penetrated by urine. Although a mattress check audit had been carried out in the service, this was at six monthly intervals and was not sufficient to identify the problem. In addition, we found that although regular pressure relieving cushion checks were carried out, these checks had not been sufficient to identify that some of these had also been penetrated by urine.

The failure to ensure that the equipment used by the service is clean constituted a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People expressed mixed views on whether there were enough staff to meet their needs in a timely way at Victoria Care Home. One person told us, "Generally speaking yes (there are enough staff), there are occasions when they are short staffed." Another person told us, "I don't think there are enough staff. They should have three (staff on unit) but they are short (staffed) today. People's relatives generally thought there were not enough staff to meet people's needs in a timely way. One person's relative said, "There aren't many staff around. Enough staff; no. We come in the morning and sometimes you are lucky to see three staff."

The staff we spoke with told us that on most occasions there was a sufficient amount of staff to meet people's needs, however this was impacted on by staff sickness and absences. One staff member said when staffing levels were low they, "can't give people enough time" and on occasions people had to wait for support.

Our observations supported what people told us. During our inspection, we found that the amount of staff on one unit did not match the number of staff identified by the provider as being required. In other units we

observed that sometimes people had to wait for support to be provided. For example, during a mealtime we saw that no staff were present in the dining room for large periods of time. We saw that one person had difficulty cutting their food up and ate very little until they were provided with support approximately 40 minutes after their meal had been served. On another occasion we saw that a person was asking staff to support them to walk to a different part of the service. We saw the person waited for approximately 15 minutes and expressed distress during this time. We viewed staff rotas which showed occasions when the amount of staff available did not match the number the provider had identified as being required. This meant that people were not supported by sufficient amounts of staff at all times.

People could not always be assured that staff were safely recruited. Records showed that one staff member had started work at the service prior to a Disclosure and Barring Service (DBS) check being carried out. The DBS carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. We discussed this with the provider who told us they believed the staff member had been attending training prior to delivering care to people. It is recommended that the provider ensures that no staff member commences working with people living at the service prior to a DBS check having been completed.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act (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. We checked whether the service was working within the principles of the MCA.

People's rights under the MCA were not always protected as the Act had not always been applied to ensure that decisions were made in people's best interests. Whilst care plans contained some assessments of people's capacity, mental capacity assessments and best interest decisions were not always in place as required. For example, a decision had been made that one person's cigarettes would be kept by staff. It was not clear whether the person had capacity to agree to this or whether the person lacked capacity and the decision had been made in their best interests. Some people living at the service had sensor equipment in use in their rooms to alert staff if they attempted to get out of bed. There was no evidence that the people whose care records we looked at had consented to this or whether they lacked capacity and the decision had been made in their best interests. This meant people's rights may not always be protected as the provider was not always acting in accordance with the MCA.

People's care records showed that their relatives had given their consent for aspects of care. For example, one person's relative had signed their consent for photographs to be taken of their relative. Another person's consent for the flu vaccine stated their family had refused. In both of these examples, there was no evidence that the relative held power of attorney which would give them the legal authority to make decisions on behalf of their relative.

The above information was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 checked the conditions of one person's DoLS and found that the provider was complying with these. It was not possible to establish whether applications had been made for reauthorisation in a timely manner when previous DoLS authorisations had expired, as the provider did not have an effective system in place to document this.

It is recommended that the provider ensures that a system is in place to ensure that DoLS applications are made when required.

People expressed mixed views on whether staff were trained and competent in meeting their needs. One person told us, "I think the staff are trained, some seem to know what they are doing." Another person

commented, "Some of the staff know what they are doing more than others."

One person's relative gave told us that staff had responded well when a person living with dementia had communicated through their behaviour. They told us that staff, "did all the right things and kept me informed so I don't worry about that." We observed that some staff responded well to the needs of people living with dementia during our inspection. For example, we saw that a member of staff ensured they responded to a person who was attempting to pull the laundry trolley along the corridor. We saw the staff member ensured the person's safety and gently and kindly explained they needed to take people's clothes to them. The staff member thanked the person for their assistance. However, on another occasion we observed a different staff member did not respond to a person's call for help. When we asked the staff member why they did not respond, they told us that the person was always calling for help. Whilst this may be the case, it did not assure us that all staff understood the needs of people living with dementia and that staff would always respond to minimise the person's distress.

We were provided with staff training records which showed a number of gaps in training which the provider had identified as mandatory for staff. For example, in relation to safeguarding adults, moving and handling and dementia awareness. The manager told us that training records were incomplete so it was not possible to establish whether staff had received the training they required. The provider told us they had identified training needs following our feedback and told us that a training plan would be developed to ensure that staff had received the training they required.

The staff we spoke with were complementary of the training provided. One staff member told us, "(Unit manager) will identify if training is needed." They provided an example of when they had requested specific training and told us this had been provided. Another staff member stated, "E-learning is loads better and we have access to policies now." Staff told us they received an induction when they commenced working at the service and had regular supervisions which provided them with opportunities to discuss their work.

People were generally complimentary of the food available at the service. One person said, "The food is very good, its five star food." Another person told us, "By and large it's good food. It's always good, always tasty. We get enough, if I don't, I just ask and I'll get more." However, some people did not feel the food was good. One person told us, "The food is terrible and sometimes cold."

We observed that people were provided with a choice of meal in generous portions. However, one person appeared overwhelmed by the amount of food on their plate and stated, "Oh, it's a lot." The person was advised by staff to eat what they could but we saw them eat very little. In one area of the service, we saw that people got very little support or encouragement to eat their meals. For example, one person left nearly their entire main course and refused the dessert. The person was not provided with any encouragement or offered an alternative. We also saw that people were not always supported by staff to cut up their meal. This meant that people may not have eaten sufficient amounts because they were not provided with support or encouragement to do so.

Risks relating to people's nutritional needs had been considered however, it was not always clear that sufficient action was taken when a risk had been identified. Records we saw showed that people's weight was monitored. One person's weight record indicated they had lost 16kg between May 2017 and November 2017.A referral was made to an external healthcare professional for support and advice in relation to the person's health deterioration in July 2017 but this was not followed up or progressed.. There was no evidence that the weight loss was part of a planned weight loss programme or that the person wanted to lose weight. The management team were aware of the person's weight loss and a referral had been made to the local authority safeguarding team which was still being investigated at the time of our inspection. In

addition, our observations showed that people were not always supported to have their meals in a consistency which was appropriate to their needs. This meant we could not be assured that action would be taken when risks were identified.

Furthermore, people's food and fluid charts did not always evidence they were eating and drinking enough. For example,guidance states that a healthy intake of fluids is between 1500 mls and 2000 mls daily. We saw that one person's fluid chart recorded they only drank 350mls throughout the day on two days. We did not see evidence that action was taken to encourage more fluid intake.

People told us they had access to healthcare professionals. One person's relative told us, "On occasions (family member) has needed an ambulance. They (staff) phone for an ambulance and then they tell us, someone goes with (family member). If they needed a doctor they call a doctor." However, people and their relatives did not always feel that staff communicated with them about their health conditions and any changes. One person's relative expressed concern about how a decision had been made about their relations heath and told us they were not informed. Another person said, "The staff communicate routine messages that's all."

People's care records showed that people had access to a range of healthcare professionals such as the GP, an optician, speech and language therapist and community nurse. However, there was a risk that people may not receive the support they required with specific health conditions, as staff did not have access to sufficiently detailed information. For example, one person had developed a pressure ulcer which was thought to have started due to moisture, as they were incontinent. The person's continence care plan did not state how frequently their continence products should be changed or what type of continence product should be used. This meant that staff may not have the guidance they required to reduce the risk of further pressure ulcers.

The visiting healthcare professionals we spoke with told us they were contacted appropriately for support when people's health needs changed. They told us they had noticed recent improvements in staff knowledge of people's needs and that generally any advice or guidance given was followed.

Information was available in the event that people needed to leave the service and go to hospital. This consisted of a personal profile, record of any allergies the person had, any medicines they took and medical conditions. This ensured that important information about the person would be available when needed if they moved to a different health or social care setting.

Victoria Care Home is comprised of two buildings, one of which had been purpose built to suit the needs of the people who lived there. One area of the home had been recently refurbished to meet the needs of people living with dementia. This was reflected in the use of signage and with sensory items available in corridoors which we observed people to use. The communal bathrooms we saw were spacious and had been adapted to suit the needs of people with limited mobility.
Call bells had been installed to assist people to summon help and an indicator system was used to alert staff whether people were being supported with personal care in their rooms so they were undisturbed. However, some people told us they could not reach their call bells which reduced their effectiveness.

Requires Improvement

Is the service caring?

Our findings

People were not always supported to maintain their privacy and dignity. For example, we observed that one person was attempting to remove an item of clothing in a communal area of the service during a mealtime. The person expressed they wanted to change their clothes and attempted to undress. Staff responded by moving the person to a different communal area of the service where they were sat on their own. The person then removed their clothing which meant they were in a state of undress. When staff noticed this they supported the person to put their top back on but did not respond to the person's requests to change their clothing. In addition to the person not being treated in a dignified manner, their requests to change their clothes were not responded to appropriately by staff.

We observed that on one unit of the service some of the gentlemen had several days beard growth. When we asked if this was in line with their preferences, they told us this was not through choice. One person when asked if he would like a shave said, "Oh yes. You don't get one in here because they (staff) haven't got time to bother with you." Another person when asked if he would like a shave said, "I'm just wondering who's going to do it" and told us the staff had enough to do. Although people told us that they were supported to have a bath or a shower, timely action was not always taken to ensure that people were kept clean. During a mealtime people were not always offered protective clothing when this would have been appropriate to keep their clothes clean and maintain their dignity. We observed that one person had food stains on their trousers and slippers and staff either did not notice or respond.

Whilst most people and relatives told us that staff spoke to them respectfully, some people expressed concern at the way staff spoke to people living at the service and a potential lack of confidentiality. One person told us, "sometimes I really don't like the way they (staff) speak to residents" whilst another person commented, "They (Staff) should stop talking about everyone." This meant that people were not assured they were always spoken to respectfully and that staff respected confidentiality.

The above information was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that most of the staff at Victoria Care Home were caring. One person told us, "It's nice, they (staff) look after you, they are good." Another person stated, "The staff are very caring to me. They listen to me and know me well." However, some of the people and relatives we spoke with told us that not all the staff were caring. One person's relative commented, "Mainly the staff are good to you but some are not so good."

The majority of interactions we observed from staff were conducted in a kind and respectful manner. Most of the time staff took action if people appeared in distress and ensured they were comfortable. For example, one person had a cold during our inspection and a staff member noticed they needed more tissues and provided these. On another occasion, we observed a staff member providing support to a person who appeared confused and was crying out. The staff member was very gentle, provided reassurance and asked the person if they would like a drink. The staff member stayed with the person and assisted them to have a

drink. We saw that this interaction provided reassurance to the person.

However, we also observed a few interactions which did not demonstrate a caring attitude. For example, we observed a staff member assisting a person to have a drink. The staff members body language did not demonstrate they had considered the most respectful way to provide support. The staff member was stood over the person with their hand on their hip whilst assisting the person to have a drink. The person repeatedly stated they did not like the drink and that it was not 'right'. The staff member replied, "well it is what you asked for, do you want it or not?" The person was coughing and the staff member was sharp in their manner throughout the remainder of the interaction. This did not demonstrate a supportive or compassionate approach to providing support.

The care plans we looked at contained personalised information about people's life history, likes and dislikes and how they should be supported. This information supports staff to provide personalised care. However, the knowledge of staff about the people they were supporting was variable and some of the people we spoke with felt that staff did not understand them well. One person told us, "The staff don't know me well at all."

We observed that most interactions between staff and people living at the home were functional and task focused. Although some staff told us they had time to sit and talk to people, we did not see much evidence of this during our inspection. However, we did observe instances of staff taking the time to comfort people who appeared to be in distress. For example, one person living at the service who was nearing the end of their life was observed being comforted by member of staff who was sat beside them and holding their hand.

People had access to independent advocacy to help them express their views. The service manager told us about one person at the service who was currently using an advocate. Advocates are trained professionals who support, enable and empower people to speak up. Information was on display within the service which informed people about local advocacy services available to them.

Some people's care plans contained information about people's level of independence including what daily living tasks they were able to do for themselves and what tasks they required support with. People told us they were supported to maintain their independence. However, some people and relatives told us that more support was required to assist people. One person's relative said, "I think they (staff) are caring and responsive to a certain degree. They think (relation) is capable and independent but sometimes (relation) needs more help than they think." Another person's relative told us, "They (people living at the service) don't get enough attention I don't think."

Requires Improvement

Is the service responsive?

Our findings

The manager told us that people and their families were invited to discuss their relatives care every six months and that staff spoke with people and their relatives if any changes occured. A few of the people we spoke with could recall being involved in the production of their care plan. One person confirmed, "I have a care plan and it's kept in the office." However, although the majority of relatives we spoke with confirmed they were involved in planning their relations care, not all of them were given the information they required or appropriate explanations about any changes. One person's relative said, "They (staff) are always bringing things to me to put a signature to but don't say what it is for. They don't explain. There's many a time (relative's) been ill and they haven't told me anything. We can usually tell (relatives) not ok and then ask and they'll say then we've done this or done that." This meant that people or their relatives were not always involved in planning and reviewing care as appropriate information and explanations were not always provided.

The provider had taken steps to identify people's communication needs. However, NHS England's Accessible Information Standard had not been fully implemented within the service. The Standard ensures that provisions are made for people with a disability or sensory impairment to have access to the same information about their care as others, but in a way that they can understand. People's care plans contained information about their communication needs, however, we found that aids people required were not always available to them or information was not clear. We observed that staff had not noticed that one person who required glasses was not wearing these during our inspection. We brought this to the attention of staff who fetched their glasses. Another person's relative told us that their relative had not always had their hearing aid available to them as this kept getting lost. One person's communication care plan stated the person was not able to make their needs known, but responded well to gestures and required time to communicate. However, their activities care plan described the person as "chatty". This presented a risk that people may not be supported appropriately to communicate and understand information.

Several people told us they could not always summon staff support when it was needed. For example, one person said, "I have a call bell but when I needed it I could not reach it." Another person told us, "I have a call bell but have to sort it out for myself. They say it's over there but of course I cannot reach it." A person's relative also expressed these concerns, "I have just picked (call bell) up from the floor. It's a new one anyway, the old one was broken. Once we told the handy man (relative) got a new one but the staff hadn't told him." This meant we were not assured that sufficient consideration had been given to people's needs to ensure they could summon support. However we observed when call bells were used, these were answered promptly

People were at risk of receiving inconsistent support. Each person who used the service had an individual care plan and those we viewed had been re-written approximately one month before our inspection. Despite this they did not always reflect people's current needs and were contradictory in places. For example, one person's personal hygiene care plan stated they were able to carry out their own personal hygiene however elsewhere in the care plan it stated the person required the support of two carers to provide support. The same person's care plan stated they were awaiting input from the falls team and were

referred in April 2017. The monthly evaluations of their care plan did not confirm they had been reviewed by the falls team or contain details of any recommendations. Another person's care plan stated that the person had been referred to the GP due to concerns about their feet. Their care plan did not confirm what the advice from the GP had been and when we spoke to staff they told us that they had been advised to keep the person's legs elevated. This meant there was a risk that care staff were not provided about clear and up to date guidance about how to best meet people's care needs.
People's care plans contained a lack of personalised information about their health needs. For example, one person's physical health care plan stated that the person 'had several co-morbidities (health conditions) which (the person) required help with' but did not give any information about what those co-morbidities were or the assistance the person needed with these. This presented a risk that people may not be fully supported to have their health needs met.
Some people had end of life care plans in place, however, these generally contained very little information about how the person wished to be cared for at their end of their life. The manager told us that some people and their families did not wish to discuss this aspect of care but in some instances opportunities to discuss this with the person or family members had not been taken. For example, one person's end of life plan stated that this aspect of care would be discussed with the family when they visited. The person's family visited most days but this discussion had not taken place. Another person's end of life care plan stated that the arrangements for after the person's death were not known but their relative, who lived abroad would deal with it. This approach may have created delays in decisions when people had passed on.
Another person's end of life care plan stated the person should be made comfortable but did not provide any information about possible symptoms they may develop and how these should be managed.
All of the above information was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were offered some opportunities to take part in activities. We spoke with an activity co-ordinator who told us that they try to find out about people's interests and hobbies and what activities they would like to do. People's opinions on the activities provided at the service were mixed. One person told us, "I get a choice about what I want to do. We can play bingo, we do karaoke occasionally, we will have a singer." However, another person told us, "I don't do any of the activities. I provide my own activities; there is not enough stimulation for me."

The service employed two activity co-ordinators who worked Monday to Friday and at the time of our inspection there was no separate budget for activities. We observed activities taking part in some areas of the service during our inspection, including karaoke, hand massage and reminiscence. We observed that the reminiscence session was tailored to the needs of people living with dementia and generated much discussion and laughter among the people who engaged with this. During our inspection, a local nursery visited and the children entertained the people living at the service with Carols. However, due to the size of the service we saw that in other areas there were no activities taking place and people were provided with limited stimulation.

Some of the people living at the service had opportunities to visit local attractions or amenities. A member of staff told us, "We organise trips out to Chatsworth, Skegness. If there's enough staff then we take them (people) into town for coffee or shopping." We observed that some of the people who lived at the service were returning from a shopping trip with a member of staff during our visit. People were also supported to maintain relationships with friends and family who told us there was no restrictions on visiting times.
The majority of people we spoke with told us they would feel comfortable making a complaint about the service but had not needed to. However, some people told us they had complained and the feedback we received about the outcome of this was mixed. One relative told us, "I have written a letter before and the manager listened and acted upon it." However another person said, "I have made a complaint but I got a lot

of backlash, it was horrible. I would not do it anymore."
We could not be assured that concerns raised about the service would always be taken seriously and acted upon. Concerns had been raised by relatives and people using the service which had not been recorded, such as unexplained bruising, concerns about staff and missing items. The manager was aware of some of these concerns and told us of the action they had taken, however some of the concerns raised were still ongoing at the time of our inspection. In addition, where concerns were recorded, sufficient action was not always taken to ensure that complaints were fully investigated and appropriately responded to. For example, during our inspection we saw that an action which had been implemented in response to a complaint was not adhered to. This meant that complaints or concerns were not always fully investigated and responded to.

The failure to ensure that complaints were investigated and necessary action taken in response was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The service was not well led. Throughout our inspection of Victoria Care Home we identified a number of serious shortfalls in the service, this included concerns related to the safety of the service, safeguarding people from abuse, medicines management and person centred care. This led to multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

It is of concern that serious risks to the health and safety of people living at Victoria Care Home had not been identified prior to our inspection. This is of particular concern given the history of non-compliance with the regulations. During our last comprehensive inspection in December 2016 we found systems in place to ensure the service was monitored and areas of improvement were identified and acted upon were not effective. In March 2016 the provider sent us an action plan stating that improvements would be completed by the end of March 2016. During this inspection, we found that people could not be assured they were always receiving care and support which met their needs and kept them safe.

There was a system of audits in place in areas such as infection control, medicines and care plans. We found these were not always comprehensive which meant that risks to people's health and safety were not identified. For example, weekly medicines audits had been carried out by senior staff members and monthly audits were carried out by the compliance manager. These audits did not identify issues with the storage of medicines, for example that medicines had not been dated on opening or that controlled drugs were not checked at the frequency required by best practice guidance. The failure to ensure robust, comprehensive audits placed people at risk of harm.

Furthermore when issues were identified, such as people not receiving their medicines, robust action was not taken by the provider to resolve the issue. The compliance manager told us they had been experiencing ongoing issues with the electronic medicines system used in the service. During our inspection we found several occasions when people had not received medicines during a previous medicines cycle as they were not available. The first day of our inspection was the first day of a new medicines cycle and we found that at least two people either did not receive their medicines that day or received them late as they were not available. This meant that effective action was not always taken to resolve issues when they were identified.

Monitoring of several areas of the service were not robust. For example, we found that records did not always reflect that people had been repositioned in line with their care plan or provided with sufficient amounts of food and fluid to maintain good health. We were told by a unit manager that records should be filled in by staff at the time that support is provided. The provider had told us in their action plan dated March 2016 that all monitoring records would be reviewed each shift with further checks carried out by the management team. Despite these previous assurances, we found that monitoring forms had not been fully completed to show that people were receiving the support they required. In addition, the management team told us they carried out informal mealtime observations but during our inspection we observed people were placed at risk of harm during a mealtime. This meant that the systems in place to monitor the service and drive improvement were not effective.

Systems intended to monitor aspects of the service were not robust. For example, the system to ensure that accidents, incidents and complaints were acted on appropriately was not effective. We found that incidents of unexplained bruising had not always been reported to the manager meaning they were not always able to investigate the possible causes of this, monitor for any trends or refer to outside agencies as appropriate. Some of the people and relatives we spoke with told us that their concerns were not always acted on appropriately. We found this to be the case during our inspection. Investigations into complaints and concerns were not always thorough and measures taken in response to concerns were not always fully implemented.

In addition, some aspects of the service were not monitored due to the lack of effective systems. For example, we were told that staff training records were not an accurate reflection of the training staff had completed due to previous information being lost. It was also difficult to establish whether applications had been made for people to be deprived of their liberty if required as this information was not collated and monitored on each unit. Furthermore some checks to the premises and equipment were marked as completed but during our inspection we found issues with the premises and equipment which had not been identified on these checks. This meant that governance systems were not always sufficient in ensuring people's safety and that people's rights were protected.

People were given opportunities to give feedback on the service they received. We found these were limited and failed to capture or address some of the feedback we received from people and their relatives during our inspection. Some of the people we spoke with told us they were not aware of any meetings they could attend to express their views about the support they received. Other people we spoke with told us the meetings were not well attended, or they were unable to attend. The manager had responded to a relatives a request to hold a meeting at a weekend but attendance at the meetings remained low. None of the people we spoke with could recall completing a quality assurance survey or being formally asked their views of the service. We were told that a quality assurance survey had been given to people and relatives in 2016 but the results of this were not available so it was not possible to determine whether action was taken in response to areas which had been identified as requiring improvement.

All of the above information was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not have a registered manager in post at the time of our inspection. The registered manager had left the service in September 2017. At the time of our inspection the manager was in the process of making an application to CQC to become registered. The manager was aware of their responsibilities, such as making safeguarding referrals to the local authority safeguarding team when required or notifying us of certain events which had taken place at the service. We found that the system for ensuring this was always done was not fully effective. For example, a safeguarding referral had not been made to the local authority when a physical altercation had occurred between two service users. The provider wrote to us following our inspection and told us about the action they would take to improve governance systems.

During our visit we saw that the ratings from our previous inspection were not on display. It is a legal requirement to display ratings. The manager assured us that the rating had previously been on display within the service and it was an oversight following a redecoration of the service. The provider told us they would rectify this immediately following our inspection.

People expressed mixed views about the atmosphere of the service. One person's relative told us, "The home is ok, everything seems ok here" whilst a person living at the service said, "The atmosphere is bad here; it's a bad place to be." People expressed that the staff did not always appear to work well as a team

and that some staff "needed improvement."

Despite these views, people and staff were complimentary of the manager who had come into post in September 2017. One person told us, "I think the manager is approachable" whilst another person commented, "[Manager] is around to chat when you want to talk." The staff we spoke with were also complimentary of the support they got from the manager and recent changes. One staff member told us, "Things are changing for the better. Staff are more motivated and get a lot of support." Another staff member said, "Working culture is better. Loads better. I would raise concerns now and feel able to make suggestions."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not always act in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The equipment used by people was not always clean.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care We were not assured that the care and treatment people received always met their needs.

The enforcement action we took:
We imposed conditions of the providers registration.

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 Care and treatment was not always provided in a safe way for people

The enforcement action we took:
We imposed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not operated effectively to reduce the risk of abuse.

The enforcement action we took:
We imposed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not always fully investigated or appropriate action taken in response to any failures identified.

The enforcement action we took:

We imposed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems and processes were ineffective in identifying and responding to issues of concern and areas for improvement.

The enforcement action we took:

We imposed conditions on the providers registration.