Four Seasons Health Care (England) Limited

Victoria Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Victoria Care Home is a residential care home registered to provide personal and nursing care for up to 53. The home supports people aged 65 and over, some of whom were living with dementia. The home is divided into two units with one unit on the ground floor and one unit on the first floor. At the time of this inspection 41 people were living at the service.

People's experience of using this service and what we found
Systems in place to monitor the quality of the service were not effectively implemented and failed to highlight or address concerns identified during this inspection. Improvements were needed to ensure the service is safe and well-led.

The care planning and recording systems in place were not fully utilised and did not ensure that up to date information was available in relation to people's needs being planned for or met. Improvements were needed to ensure that people's medicines were safely managed and the process to be followed for referring incidents under agreed safeguarding procedures.

People were supported by sufficient staff so that their needs and wishes could be met.

People were supported by staff who had access to and received training in relation to Health and Safety and Safeguarding.

The provider had identified areas of improvement needed at the service and was in the process of implementing an action plan to make the improvements.

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

Rating at last inspection
The last rating for this service was Good (published 21 December 2019).

Why we inspected
This inspection was planned in response to receiving information about incidents and falls that had recently occurred within the service.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led

sections of this report.

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

During the inspection the provider took action to mitigate identified risks.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe	**Requires Improvement**
Is the service well-led? The service was not always Well-led.	**Requires Improvement**

Victoria Care Home

Detailed findings

Background to this inspection

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

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

Inspection team
This inspection was carried out by two inspectors. One inspector visited the service and the other inspector worked remotely reviewing and assessing information supplied by the service.

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

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

Notice of inspection
We announced this inspection half an hour prior to the visit taking place.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and four family members by telephone about their experience of the care provided. We spoke with seven members of staff including the provider, registered manager, nurses, care workers and the maintenance person.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data; quality assurance records and care records.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- People's medicines were not always safely managed. Policies, procedures and good practice guidance in place for the safe management of people's medicines were not always adhered to.
- Missed doses of medicines for one person were recorded with no explanation and medicines records from the previous months could not be located.
- One medicines storage room was being used to store equipment and was untidy.
- Homely remedies were in use for people when required. However, we found homely remedy medicines that were past their expiry date. Prescribed creams in use did not always state the date of opening.
- Specific guidance for staff on risk, signs and indicators for the administration of medicines prescribed on an 'as and when' basis were not always available. In addition, Guidance for staff in relation to medicines that had potential side effects for people were not always in place or detailed.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate medicines were effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection to address the areas of improvement needed.

- People were supported to take their medicines by staff who had received training and deemed competent in the administration process.
- One family member told us since living at Victoria Care Home, their relatives medicines had been reviewed and changed which had resulted in improvements to their health.

Assessing risk, safety monitoring and management

- People's care planning documents were not consistent in detailing potential risks for people. Care plans did not always identify, consider, plan or monitor known risks to people health. For example, no assessment of risk had been carried out for one person who had a specific health condition that put them at risk.
- Other people's risk assessments were only partially completed. This put people at risk from not receiving the care and support they required.
- Individual risk assessments failed to consider specific risks to people from the Covid-19 pandemic.
- Regular checks were carried out throughout the building and on equipment in use. However, potential

risks to people's living environment had not been minimised, reported or addressed. For example, a number of bedroom doors failed to close effectively. This could have put people at unnecessary risk of harm.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate risks to people's safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection to address the areas of improvement needed.

● Staff had received training in health and safety.

Systems and processes to safeguard people from the risk of abuse
● Safeguarding procedures were in place. However, these procedures were not always implemented. For example, one incident had not been reported appropriately to the Local Authority under the joint agency safeguarding procedure. This resulted in a delay in investigations into the incident taking place.

Systems in place for the identifying and reporting of safeguarding concerns were not effectively implemented. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection to address the areas of improvement needed.

● Staff had access to information about how to protect people from harm.
● The majority of staff had completed training in relation to safeguarding people.

Staffing and recruitment
● The provider had clear recruitment procedures in place. Appropriate checks were carried out on applicant's suitability for the role prior to them commencing employment.
● The provider was actively recruiting to fill a number of vacancies at the home. The level of vacancies required agency staff to be employed to ensure sufficient staff were on duty to meet people's needs.
● Rotas showed that sufficient staff were available at all times.

Learning lessons when things go wrong
● Procedures were in place to support staff in responding and recording accidents and incidents that occurred.
● Information relating to accidents and incidents was reported to the provider on a weekly basis. This enabled the provider to monitor; review and make improvements when things went wrong.

Preventing and controlling infection
● Procedures were in place to maintain a safe and clean environment for people to live. These procedures included specific guidance in relation to the Covid-19 pandemic. For example, specific guidance was in place for meeting social distancing rules; use of personal protective equipment; admitting people safely; promoting safety through increased hygiene practices and people and staff having regular access to testing.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Systems in place for the monitoring of and ensuring quality and safety were not always effective and put people at risk of not receiving the care and support they needed. Monitoring systems had failed to identify improvements needed in relation to identifying and mitigating risk. For some people, identified risks had not been considered and appropriate care planning had not been developed to mitigate the risks.
- Records for some people failed to demonstrate their individual needs and how these needs were to be met. A number of assessment; monitoring records and care planning documents were either not completed or only partially completed.
- Records relating to assessments under the Mental Capacity were not always completed appropriately. For example, records indicated that one person lacked capacity to make a specific decision, no capacity assessment had taken place. For another person, where a formal capacity assessment had been completed in considering the use of a piece of equipment, the document failed to demonstrate that the principles of the Mental Capacity Act had been considered.
- The application of the systems in place for the oversight and monitoring of people's care planning documents were not effective. It failed to identify the missing information in people's care records with regards to the planning of people's care.

Systems in place were not applied to demonstrate that governance within the service was effective. This placed people at risk of not receiving their planned care. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection to address the areas of improvement needed

- The provider had identified some areas of improvement needed and was in the process if implementing an action plan to make improvements within the service. Following this inspection, additional actions were added to the action plan.

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

- The registered manager and the provider had an understanding of their responsibilities in responding to

people who use the service under the duty of candour following incidents and when things have gone wrong.

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

- The Care Quality Commission was informed of incidents and events which occurred at the service in line with regulatory requirements. However, we identified incidents and events that had not been reported appropriately. We raised with the provider.

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

- During the pandemic alternative ways for people to maintain contact with the family and friends had been introduced. This included via social media groups; video and telephone calls.
- Two family members told us that communication had not always been effective. Others told us that the service communicated with them well and that they had regular contact with their relatives. One family member said that their relative chooses to speak to them by telephone. Other comments from family members included, "She loves it"; "Mum feels safe"; "Mum makes her own decisions" and "Mum's ok and doing ok. Well looked after."

Continuous learning and improving care; working in partnership with others

- In response to areas of improvement identified by the provider prior to this inspection, additional management support had been provided to make improvements needed within the service.
- Staff had access to and completed training to ensure they had up to date knowledge for their role. The provider had a training programme that was accessible electronically to staff.
- The service worked with and had access to support from the Local Authority and Clinical Commissioning Group for monitoring people's health and advice for improving the service. Alternative ways of communicating with healthcare professionals and specialist community teams were in place throughout the pandemic. The manager explained that due restrictions consultations had taken place by phone; video call or sharing information electronically with health professionals for review.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were either not in place or robust enough to demonstrate safety and medicines were effectively managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems in place for the identifying and reporting of safeguarding concerns were not effectively implemented.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place were not applied enough to demonstrate that governance within the service was effective.