Liberty Healthcare Solutions Limited

Vale Court 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
Vale Court is a residential care home providing nursing care to up to 59 people. The service provides support to older people and those living with dementia in one purpose-built building. At the time of our inspection there were 58 people using the service.

People's experience of using this service and what we found.
The governance of the service was not always effective. For example, people at risk of dehydration did not have their intake of fluids recorded accurately despite new recording systems being introduced a few months prior to our visit. This meant the service could not always evidence effective oversight to ensure people were not at risk.

Auditing systems had not identified safeguarding events and as a result been reported to other agencies for investigation. The provider responded by introducing new systems and safeguards to ensure this did not re-occur and had sent notifications to CQC retrospectively.

Daily records were not always specific for those living with dementia. Records made reference to "distraction techniques" in order to reduce distress in individuals yet there was no indication as to what these involved. Records also made reference to people being "non-compliant" in their support which did not take their dementia experience into account. Staff outlined recent dementia training had been received which the registered manager considered had been beneficial to better understand people.

People appeared to be safe and relaxed with the staff team. Nursing and senior care staff were clear about the processes they need to follow to escalate any safeguarding events to the registered manager.

Medication systems were safe with people receiving their medications in a timely manner. Recruitment processes were robust and staff were available to attend to the needs of people.
The building was well maintained, clean and hygienic throughout. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection and update
The last rating for this service was good (published 27 July 2018).

Why we inspected
The inspection was prompted in part due to concerns received about safeguarding incidents. A decision was made for us to inspect and examine those risks.

You can see what action we have asked the provider to take at the end of this full report.
For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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

We have found evidence the provider needs to make improvements. Please see the safe and well led sections of this full report.

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

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

Enforcement and Recommendations
We have identified breaches in relation to governance systems at this inspection. We have made recommendations in relation to the provider sustaining new systems put into place for ensuring people are protected from abuse, monitoring where there are many conditions placed onto deprivation of liberty orders and in building staff knowledge in the needs of those living with dementia.

Please see the action we have told the provider to take at the end of this report.

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

For more details, please see the full report which is on the CQC 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?

Requires Improvement

The service was not always safe.
Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.
Details are in our well led findings below.

Vale Court Care Home

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by 2 inspectors.

Service and service type
Vale Court is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Vale Court is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

This inspection was unannounced on the first 2 dates and announced on the third date.

What we did before the 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 (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 12 members of staff including the nominated individual, registered manager, unit managers, registered nurses, senior care workers, carers and ancillary staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. This included 7 people's care records, risk assessments and medication records. We looked at 4 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.

We spoke with 5 residents and 4 relatives about their experience of the care received. 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.

Requires Improvement

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

- Records indicated people at risk of dehydration did not reach fluid targets consistently.
- Records indicated one individual had not had their assessed fluid target met for 10 days over a fortnight. Another indicated targets had not been reached over 11 days.
- The registered provider had introduced a recording system for the identification of such instances in January 2023, yet there was no evidence this had been effective or evaluated in light of missed fluid targets identified during the inspection. As a result, people remained at risk.

The provider did not have safe systems for assessing and monitoring risk to people. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We observed one person being provided with a drink and breakfast while they were lying down and were clearly struggling to eat and drink from their position. Their medication care plan was clear about repositioning the person to take medication, but this had not been extended to eating. Care plans had been reviewed and updated subsequently in response to our observations.
- People who were unable to reposition themselves in bed relied on staff to assist them in order to prevent their skin breaking down. The assessed target was every four hours. This was not always recorded and some people were only repositioned after 8 to 12 hours on some occasions. As a result of our initial findings, the registered manager had investigated this and, while people were being repositioned, this had not always been recorded. The registered manager had subsequently reinforced the need for staff to accurately record all interventions.
- People at risk of malnutrition had their food intake recorded. Initial records looked at suggested there was basic detail on the food intake of those at risk of malnutrition. The registered manager subsequently provided additional information giving a more detailed account of people's nutritional intake.
- Regular checks on equipment used as well as fire detection and prevention systems were in place.

Learning lessons when things go wrong.

- Arrangements were in place for the recording of accidents and incidents as they occurred.
- Effective analysis of these could not be achieved as many events were still pending review or had not been signed off by the registered manager. This included all accidents and incidents that had occurred since December 2022 up to the date of inspection.
- The provider told us two systems had been used to record events. One was a paper-based system and the

other recorded through computerised systems and this had been reviewed in March 2023 with all incidents/accidents being digitalised.
● Despite this, we identified 6 records still required to be signed off with 6 pending. As a result, it could not be evidenced there was an effective oversight of incidents.
● This combined with the non-reporting of safeguarding incidents meant lessons could not be learned from events which had occurred and remedial action to prevent re-occurrence could not be undertaken.

Systems had not been followed to ensure effective oversight of incidents and accidents had been experienced by people using the service and no action had been taken to remedy these. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Systems and processes to safeguard people from the risk of abuse.
● People had not always been safeguarded from the risk of abuse.
● Some safeguarding incidents had not been reported to CQC or the local authority as required. These went back to 2022. This meant preventative measures or agreed actions to prevent harm to people had not been investigated.
● The registered provider had submitted notifications of incidents retrospectively and had introduced systems to promote effective oversight of safeguarding incidents.
●These had included weekly meetings between the registered manager and other managers as well as a 24-hour daily record where safeguarding events could be recorded and passed to the registered manager for oversight and actioning.

We recommend the registered provider continues to use and evaluate the systems introduced in response to our inspection so people are safeguarded from abuse.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service were working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.
● A file was available outlining all the deprivation of liberty orders had been authorised.
● Conditions attached to one person's deprivation of liberty order was very specific and the log did not maintain always an update as to whether these conditions were being met.

We recommend the provider consider including information in the Deprivation of liberty file to include progress for those people who have very specific conditions attached.
● The capacity of individuals to make decisions had been assessed.
● Staff had received training in the Mental Capacity Act.

Staffing and recruitment
● Staffing levels met the needs of people.
●Rotas outlined the mix in skills and experience of staff throughout the day and night.
● Recruitment of new staff was robust.

Using medicines safely
● Medicines were safely managed.
● All medicines were safely stored and controlled drugs were separately stored and accounted for.
● Plans for covertly given medication was in place and had been put into place following best interest meetings for those who lacked capacity.
● Protocols for the use of 'when required' (PRN) medications were in place to ensure consistent administration of painkillers, for example.
● Staff responsible for the administration of medication had their competency assessed to do this safely.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
People living at Vale Court were able to receive visitors.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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; Continuous learning and improving care.

- Governance of the service had not been consistently effective.
- For example, systems put into place to ensure people were not at risk of dehydration, had not been subject to appropriate governance.
- Accidents and incidents were not being consistently and routinely reviewed with the result actions to minimise the prevention of future re-occurrence of accidents could not be achieved.
- Some safeguarding events had not been reported to CQC and local authorities. As a result, people had been at risk of harm. In response to our findings, the provider introduced systems such as, more frequent management meetings and feedback to staff about reporting safeguarding incidents and the need for accurate recording.

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

- People did not always receive consistently person- centred care.
- Terminology in records referred to people "being compliant", using "distraction techniques" and recording "agitation" without elaborating on what these meant in relation to people living with dementia.
- Staff told us they had recently attended dementia training and had found this invaluable.

We recommend the provider uses the staff knowledge gained following this training to better understand the experiences of those living with dementia.

- Other practice observed was person- centred. People were transferred by staff, for example, in a patient and unhurried manner.
- Staff worked consistently to gain appropriate medical attention for one person with the result a positive outcome was achieved for individual.
- Staff told us the registered manager was approachable and always provided to support to them.

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

characteristics; Working in partnership with others

● The service had not always maintained partnerships with the local authority with some safeguarding incidents not reported.

● The registered provider had subsequently met with representatives from the local authority safeguarding team to foster relations and improve partnership working.

● Surveys had been sent to people, their families and staff in 2022.

● We were provided of a summary of received comments made by all stakeholders.

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 17 HSCA RA Regulations 2014 Good governance The provider had failed to maintain effective governance systems to ensure that people were not at risk .