Partnerships in Care (Vancouver) Limited

Vancouver House

Inspection report

Vancouver Road
Gateacre
Liverpool
Merseyside
L27 7DA

Tel: 01514876905
Website: www.healthandsocialcarepartnerships.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Vancouver House is a care home providing personal and nursing care to adults aged over 18. The service can support up to 32 people. 17 people currently live at Vancouver House.
There are four units across two floors and all four units are in use. Vancouver House supports people with a learning disability, autism and people with mental health needs.

People's experience of using this service and what we found
The service was not safe. People's support plans were not always followed and there was a high reliance on agency staff. This meant staff did not always have the right knowledge or experience to meet people's assessed needs. The medicines policy was not always followed, and we found gaps in how the provider reduced the risk of spread of infection.

The service was not effective. People's needs were not always met in line with guidance. Staff did not have the right level of induction, training, skills or experience. We were not assured the provider always had consent to care and treatment in line with law and guidance.

The service was not well led. The concerns noted during the inspection had not been addressed by managers, and there had been no improvement since the previous inspections. There was a poor culture at all staff levels and management.

People were supported to have maximum choice and control of their lives. Although there were policies in place, staff did not always support people in the least restrictive way possible, and this was not monitored effectively by the provider.

Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

This service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture. Health and social care providers are required to ensure autistic people and people with a learning disability have the choices, dignity, independence and good access to local communities that most people take for granted.

The model of care had an institution type feel and did not meet the principle of Right support. Some staff were committed to providing person-centred care however sometimes people's dignity and privacy were not respected.
The provider acknowledged these issues and planned changes, however, were met with logistical challenges making it difficult to make the desired changes. Plans included reducing the size of the service to one unit instead of four, and to update and modernise the environment.

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 requires improvement (published 1 April 2021) and there was one breach of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulation.

Why we inspected
Through regular meetings with the provider and commissioners, all parties were aware of and acknowledged concerns in relation to the management of incidents, staffing and leadership of the service. As a result, we undertook a focused inspection to review the key questions of safe, effective and well led.
We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.
We have found evidence that the provider needs to make improvement. Please see the relevant key question sections of this full report. You can see what action we have asked the provider to take at the end of this full report. The provider has taken some action to mitigate the risks which is under constant review.
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.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to staff recruitment, management of risk, monitoring the quality of the service, and ensuring consent for care and treatment.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe, and there is still a rating of inadequate for any key question or overall rating, we will act in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Vancouver House

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
The inspection was undertaken by an inspection manager, five inspectors and a medicines inspector.

Service and service type
Vancouver House 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 does not have a manager registered with the Care Quality Commission. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 19 August 2021 and ended on 24 August 2021.

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. 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 this information to plan our inspection.

During the inspection
We spoke with two people who used the service and a relative about their experience of the care provided. We spoke with fifteen members of staff including the provider, managers, nursing staff, care staff and kitchen staff.

We reviewed a range of records. This included five people's care records and several medication records. We looked at 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.

Inadequate

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 requires improvement. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
- Systems were not in place to manage risk.
- Environmental risks were not managed. For example, we found fire doors were missing in two communal lounges. The provider had ordered new fire doors however, the fitting of them was delayed.
- We found evidence of broken equipment such as window restrictors.
- We found that although people had support plans in place, staff were not always following; for example, around diabetes management or choking risks.
- People who had behaviours which may challenge were not always supported effectively. Inexperienced staff without relevant training were supporting people. We found that people were not being supported to access community activities.

We found no evidence that people had been harmed however, systems were not in place to demonstrate risk 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 above concerns were raised during and after the inspection. The provider addressed issues including fitting new fire doors and window restrictors. They reviewed risk assessments and support plans and made changes to ensure staff were aware of them and followed them.

Staffing and recruitment
- There were not always the right amount of staff with enough skills and experience to meet the needs of people.
- There were no permanent registered nurses on duty during the night. We found this caused problems with handovers and communication.
- There were not enough senior care staff in place to support new and inexperienced staff.
- The provider was struggling to recruit permanent staff meaning there was a high number of agency care staff. We found agency staff did not have the same level of training as permanent staff. This meant that people could not access their two to one support in the community, which at times exacerbated management of people's needs and behaviours which may challenge.
- The provider did not have systems in place to ensure safe recruitment practices of agency staff.

We found no evidence that people had been harmed however, the heavy reliance on agency staff placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

Using medicines safely
● Medicines were not managed safely, and the medicines policy was not always adhered to.
● At times medicines were not administered as prescribed or stored and disposed of safely.
● Medicines were not always available, and we found instances where people had missed their medication.
● Observation scores for pain and blood sugars were not always recorded and it was not clear what action staff took when there were signs of ill health.
● Signatures were missing for medicine documents and some medicines did not have people's names on.
● Staff did not keep accurate records about medicines such as paracetamol and fluid thickener, and whether they were managed according to people's care plans.

We found no evidence that people had been harmed however, the provider's medicine policy was not being followed, and systems did not ensure that medicines were being managed safely, placing 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 agreed to take action to address. These included completing daily reviews of the care of residents with complex needs to ensure medicines were being administered as prescribed, and for staff to complete competency assessments.

Preventing and controlling infection
● We were not assured that the provider had systems in place to reduce the spread of infection.
● We saw that staff were not always wearing masks, so we were not assured the provider was using PPE effectively and safely.
● We were not assured that the provider was accessing testing for people using the service and staff.
● High touch point areas were not being cleaned regularly, and cleaning checklists were not always ticked and signed.
● We saw that some areas were unclean.

We found no evidence that people had been harmed however, systems were not in place to demonstrate that the risk of the spread of infection 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 took action to address the issues identified by inspectors, including checks of cleaning of high touch point areas.

Learning lessons when things go wrong
● The provider did not have systems in place to monitor incidents and learn from them to improve the service.
● Staff completed incident forms however recording was poor, meaning it was difficult to identify if staff were undertaking safe practices.
● We could not see that themes were being identified from incidents, which meant opportunities to learn from and improve practice were missed.
● There was confusion amongst staff and managers about the incident recording process and we could not see a policy to guide staff on recording, analysing and learning from accidents and incidents.

We found no evidence that people had been harmed however, systems were not in place to monitor and learn from incidents, placing people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- There was a safeguarding policy in place which staff were aware of.
- Staff took part in safeguarding training and understood their responsibilities.
- The provider worked closely with the local authority in response to safeguarding concerns.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience/ Supporting people to eat and drink enough to maintain a balanced diet

- There was a lack of senior care staff to provide leadership and mentoring.
- Agency staff did not receive the same training as permanent staff, for example use of restraint.
- The provider told us they completed staff supervisions and worked to improve culture. However, they acknowledged this was not successful in all instances due to historic issues. Some staff told us they did not feel supported by their managers.
- Record keeping of fluid intake was poor, so we were not assured that people received enough fluids according to their care plan.

We found no evidence that people had been harmed however not all staff had the right skills and experience and were not assured that people received the correct amount of fluids. This placed people at risk of harm and was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was aware and planned to work with agencies to ensure staff received the same level of training. They put measures in place to address quality of recording.

- There were two kitchen staff employed on a full-time basis. They had good knowledge of people's individual needs, and preferences. Food was prepared, labelled and stored separately.
- People had a choice of menu options and the chef prepared individual meals if people preferred something different.

Ensuring consent to care and treatment in line with law and guidance/Assessing people's needs and choices; delivering care in line with standards, guidance and the law

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Most people that were being deprived of their liberty had the correct paperwork in place. However, we found one person where this had expired.
- We found that not all staff had a sound understanding of the principle of using least restrictive options.
- Not all staff working with people had received the correct restraint training, and at times unauthorised techniques were used.

We found no evidence that people had been harmed however we were not assured that the relevant consent and decision-making requirements of legislation and guidance were being followed. This placed people at risk of harm and was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider agreed to address issues and review people's care plans.

Staff working with other agencies to provide consistent, effective, timely care/Adapting service, design, decoration to meet people's needs

- Staff made referrals to other agencies such as speech and language therapists, dieticians and occupational therapists.
- Vancouver House had an institution type feel and the environment was not homely or comfortable. There had been attempts made at re-decorating and the provider told us further adaptations were to be made.

Supporting people to live healthier lives, access healthcare services and support

- It was not clear what support was in place for people to live healthier lives.
- The reliance on agency staff meant sometimes people could not access their two to one support. This limited the time that people could leave the unit and spend time outdoors and in the community.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection the provider had failed to make sure there were systems to monitor the quality and safety of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider continued to be in breach of regulation 17.

- There was no registered manager in post and the provider had not made an application.
- There was inconsistent leadership; several managers were appointed in the past two years. The provider told us they struggled to recruit and retain permanent managers.
- The provider had not improved following the previous three inspections which were rated requires improvement.
- The provider did not manage risks effectively. Policies were not being followed, for example the medicine policy and we could not see how this was being monitored or addressed.
- Risks identified in people's care plans were not being managed effectively; we could not see how this was being monitored or addressed.

We found no evidence that people had been harmed however we were not assured that the provider was managing quality performance and risk. This placed people at risk of harm and was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- We found a poor culture at the service. Managers told us they attempted to improve however, this had not always been responded to well, and staff told us they felt unsupported.
- There was a high number of staff resigning, after working at the home for several years.
- Staff surveys indicated that staff were not happy in their roles.

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 provider did record incidents and there was some analysis undertaken.
● It was not clear whether this was consistent, and staff did not always receive feedback.
● Therefore, we could not see whether the provider acted on their duty of candour in all instances.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider made some attempts at engaging with staff through meetings however they told us the response was limited.
Continuous learning and improving care
● It was not clear how the provider engaged in continuous learning to improve care.

Working in partnership with others
● The provider worked in partnership with others, such as health professionals, safeguarding teams and commissioners.

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 11 HSCA RA Regulations 2014 Need for consent People were not protected from the risks associated with the requirement for consent and decision-making being followed.

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 People were not protected from risks as people's care plans were not followed. People were not protected from risks due to unsafe management of medicines. People were not protected from the risk of spread of infection. People were not protected from risks associated with high numbers of agency staff who did not have the right levels of training and experience to meet people's needs. People were not protected from the risks associated with unsafe environment.

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 did not have governance systems in place to effectively manage risks and identify when improvements were required.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

Treatment of disease, disorder or injury

People were not protected from the risks associated with lack of permanent staff including registered nurses during the night; lack of senior care staff to provide leadership; high reliance on agency staff who did not have the same level of training.