Sun Care Homes Limited

Victoria Cottage Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**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

We conducted an unannounced inspection at Victoria Cottage on 24 May 2018. Victoria Cottage is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Victoria Cottage accommodates up to 18 people in one building. On the day of our inspection, nine people were living at the home; all of these were older people, some of whom were living with dementia.

This service is also registered as a domiciliary care agency. This means it can provide personal care to people living in their own homes. At the time of our inspection, no one was being supported in their own home.

At the last inspection in May 2017, we asked the provider to take action to make improvements to risk management, in particular risks associated with falls. During this inspection, we found that although the management of falls risk had improved, risk management in other areas had deteriorated. We also identified concerns in relation to safeguarding people from abuse, staff training and competency and governance and leadership. We found five 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 the report.

There was no registered manager in post at the time of our inspection. The previous registered manager had left the home in January 2018. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was a service manager in post who told us they were planning to register. We will monitor this.

During our inspection we found the service was not safe. People were not always protected from risks associated with their care and support. People were placed at risk of choking as risks were not assessed and staff did not have access to guidance to inform their care and support. Moving and handling risk assessments had not been updated to reflect changes in people's needs, which meant staff did not have the most up to date information about how to safely support people. People were subject to unsafe and restrictive interventions as staff were not provided with information about how to manage behaviours resulting from anxiety and distress. Serious incidents were not investigated; this meant action had not been taken to reduce the risk of reoccurrence.

People were not protected from abuse and improper treatment. We found evidence of a number of incidents that had not been referred to the local authority safeguarding adults team for investigation. The cause of unexplained marks to people's skin were not investigated. Infection control and prevention measures were not effective, this exposed people to the risk of infection spreading. People could not be assured that good hygiene practices were followed, effective cleaning procedures were not in place for

some items of equipment and some areas of the home.

There were enough staff to meet people's needs and ensure their safety. Safe recruitment practices were in place to reduce the risk of people being supported by unsuitable staff. Overall, medicines were stored and managed safely. However, medicines errors were not always identified and investigated, and topical creams were not always administered as required.

People were supported by staff who did not always have appropriate training or support. Temporary agency staff did not have training in key areas and when staff moved into new roles within the home they were not given additional training to support them to fulfil their duties.

Systems to protect people from risks associated with eating and drinking were not always effective. We received mixed feedback about the food. Records did not consistently demonstrate people had been provided with enough to drink. Staff did not always have sufficient information to promote good nutritional intake and people's dementia related needs had not been considered at mealtimes.

People were supported to have maximum choice and control of their lives; the policies and systems in the service supported this practice. People had access to healthcare and their health needs were monitored and responded to. There were systems in place to ensure information was shared across services when people moved between them. The design and decoration of the building accommodated people's diverse needs.

People did not consistently receive caring support. Permanent staff were kind and caring, had an understanding of what was important to people and how to communicate with them. However, people told us temporary agency staff did not always treat them in a respectful and dignified manner. The language used by staff to describe people did not always promote their dignity.
People were supported to be as independent as possible. People were involved in day-to-day choices and decisions and in planning their care and support. People had access to advocacy services if they required this to help them express their views. People's right to privacy was respected.

People were at risk of receiving inconsistent support as care plans did not all contain accurate, up to date information. Care records did not evidence that people received the care they required to meet their needs. People were provided with opportunities for social and recreational activity.
People's friends and family were welcomed into the home and were involved in the care and support of their loved ones. People were provided with an opportunity to discuss their end of life wishes and this was compassionately recorded in people's care plans. There were systems to investigate and respond to concerns and complaints; however these systems were not always followed which meant the provider could not assure us complaints had been handled properly.

Since our last inspection there had been a deterioration of the quality, safety and leadership of the service. Improvements noted at our last inspection had not been sustained and consequently people were placed at risk of harm. Systems to monitor and improve quality and safety were not consistently effective in identifying and addressing areas for improvement. Improvements had not always been made, or sustained, in response to known issues. Records of care and support were not accurate or up to date and staff did not always have access to clear information about the people they were supporting. In addition, audits of care plans were not effective. Sensitive personal information was not stored securely. Staff and people living at the home were able to express their views in relation to how the service was run.

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 always protected from risks associated with their care and support. Accidents and incidents were not adequately investigated.

Effective processes were not in place to protect people from abuse and improper treatment.

People were not adequately protected from the risk of infectious disease.

There were enough staff to meet people's needs and ensure their safety. Safe recruitment practices were followed.

Overall, medicines were stored and managed safely. However, medicines errors were not always identified and investigated.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported by staff that did not always have appropriate training to enable them to carry out their jobs safely and effectively.

Systems to protect people from risks associated with eating and drinking were not always effective. We received mixed feedback about the food.

People were supported to have maximum choice and control of their lives; the policies and systems in the service supported this practice.

People had access to healthcare and their health needs were monitored and responded to.

The environment was adapted to meet people's needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Permanent staff were kind and caring, had an understanding of what was important to people and how to communicate with them. However, people told us temporary agency staff did not always treat them in a respectful and dignified manner.

People were supported to be as independent as possible. They were involved in choices and decisions about their support and had access to advocacy services if they required this.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People could not be assured that they would receive the support they required, as care plans did not all contain accurate, up to date information about the support people needed.

People and their families knew how raise issues and concerns; however, systems in place to manage complaints were not effective.

People were provided with opportunity for meaningful activity.

People were given the opportunity to discuss their end of life wishes.

Is the service well-led?

Inadequate

The service was not well led.

Systems to monitor and improve the quality and safety were not consistently effective.

Action was not taken in response to known issues.

Records of people's care and support were not accurate or up to date.

Sensitive personal information was not stored securely.

Staff and people living at the home were able to express their views about how the service was run.

Victoria Cottage Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

Before our inspection, we reviewed information we held about the service. This included information received from local health and social care organisations and statutory notifications. A notification is information about important events, which the provider is required to send us by law, such as, allegations of abuse and serious injuries. We also contacted commissioners of the service and asked them for their views. We used this information to help us to plan the inspection.

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.

One inspector and an inspection assistant undertook the inspection. During our inspection visit, we spoke with two people who lived at the home and five relatives. We also spoke with two members of care staff, a member of the catering team, the team leader, the manager and a project manager. In addition, during the course of our inspection we spoke with three external health and social care professionals.

To help us assess how people's care needs were being met we reviewed all, or part of, six people's care records and other information, for example their risk assessments. We also looked at the medicines records of four people, four staff recruitment files, training records and a range of records relating to the running of the service. We carried out general observations of care and support and looked at the interactions between staff and people who used the service.

We asked the manager to send us a copy of various policies and procedures and we received this prior to this report being completed.

Inadequate

Is the service safe?

Our findings

At our May 2017 inspection, we found action had not been taken to protect people from the risk of falls. This was a breach of the legal regulations. Although we found improvements in falls risk management at this inspection, we found concerns about other areas of risk management, which placed people at risk of harm.

People were not protected from the risk of choking. A member of staff told us two people had experienced recent choking incidents. They told us one person had, "Turned a funny colour" as the result of a choking incident. We checked these people's care plans and found there was no record of either person choking, no risk assessment and no guidance in their care plans to reduce the risk of them choking. Furthermore, both people's care plans explicitly stated they were not at risk of choking. This failure to identify, assess and manage choking risk placed people at risk of serious harm.

People were not protected from risks associated with moving and handling. Moving and handling risk assessments had not been updated to reflect changes in people's needs. Consequently, some care plans did not contain important details about how to use mobility equipment or the impact of any physical limitations the person may have. One person's needs had changed in the weeks before our inspection. This meant they required the support of two staff to enable them to mobilise using a hoist. Despite this, their moving and handling care plan and the risk assessment had not been updated to reflect this. Consequently, there was no information on the type of sling, how to use it or how to support the person. This meant staff did not have sufficient guidance to inform safe care and support and placed people at risk of harm.

Bedrails were not always used safely. Although risk assessments had been completed when people used bedrails, these were not always robust. One person used bedrails to prevent them from falling out of bed. A bedrail risk assessment had been conducted in December 2017 which assessed that the bedrails were safe and there was no risk of the person climbing or falling over them. An incident record, dated 2 January 2018 documented that the person fell over their bedrails and sustained an injury. The failure to conduct an effective bedrail risk assessment resulted in this person experiencing harm that may have been avoidable.

Serious incidents were not investigated; this meant action had not been taken to reduce the risk of reoccurrence. One person had recently sustained a serious injury requiring hospital treatment. Although the circumstances of leading to the injury were unwitnessed by staff, records showed staff believed the person had trapped their finger in a door. The manager told us they had 'looked into' the incident but had not conducted a formal investigation of what happened. Consequently, no action had been taken to reduce the risk of this happening again. This failure to learn from accidents and incidents placed people at risk of harm. After our inspection, the project manager shared new procedures and forms with us which they planned to implement to improve the management of incidents. We will assess the impact of this at our next inspection.

People did not always receive appropriate support with behaviours arising from anxiety and agitation. Care plans did not always contain a sufficient level of detail to inform staff about how to support people whose behaviour could put them and others at risk. One person frequently behaved in a way that put others at risk.

Their behaviour care plan contained basic information about their behaviour but this was not up to date and it did not contain clear information about how to minimise the risk or what staff should do should the person's behaviour escalate. Staff told us, and behaviour records showed that staff were using restrictive and potentially unsafe techniques to manage their behaviour. For example, staff frequently removed the person's walking stick to reduce the risk of harm to others. This restricted the person's freedom and increased the risk of the person falling. This did not respect the person's rights and placed them at risk of harm at risk of harm.

In addition, there was no system to learn from people's behaviours to develop and improve the support they received. Charts used to record people's behaviours were not used to learn about triggers to behaviours and how best to support them. This meant opportunities to improve people's support may have been missed. After our inspection, the project manager shared a range of new forms with us that they planned to implement to improve the recording and monitoring of people's behaviours. We will assess the impact of this at our next inspection.

People were not adequately protected from the risk of infectious disease. One person who used the service had an infectious disease. We reviewed records and found there was no person specific protocol for preventing the spread of the infection. There was information printed from the internet displayed at the home; however, we found this guidance was not being followed in practice. For example, infectious waste bags were not in use and there were not sufficient handwashing facilities available in the person's bedroom. This placed people who used the service at increased risk of contracting an infectious disease. Following our inspection visit, we informed the local infection control team of our concerns who provided the home with support to ensure good infection control procedures were in place.

People could not be assured that good hygiene practices were followed. Although we found, overall, the environment was clean and hygienic, effective cleaning procedures were not in place for some items of equipment and some areas of the home. We observed mobility equipment such as hoists and wheelchairs were not clean. In the laundry, there was a build-up of washing powder on the floor, in the washing machine drawer and drum. These unhygienic practices did not promote the control and prevention of infection. Following our inspection visit, the project manager informed us new cleaning schedules were being implemented. We will assess the impact of this at our next inspection.

There were no effective systems in place to identify and investigate medicines errors or incidents. The manager told us they had not had any recent medicines errors. However, we found some medicine in the medicines cupboard, which had been marked as being found on the person's bedroom floor. This had not been reported as a medicines incident and consequently no investigation had taken place to review the person's support and try to prevent this from happening again. Records showed the same person had recently declined to take some of their medicines, this had not been reported and consequently their care plan had not been reviewed to reflect this and provide staff with guidance about what to do if they declined to take their medicine.

When people were prescribed creams for topical application staff did not always record the application of these creams. For example, one person was prescribed a cream for topical application three times a day. The cream had only been applied twice on 22 of 23 days prior to our inspection. This meant topical creams were not being applied as required which could have a negative impact on people's skin health.

People were put at risk of eating food that was not safe to eat because basic food hygiene practices were not followed. We found that food was not stored safely. For example, we observed loose vegetables stored at floor level in close proximity to an open external door. This could pose a risk of pest infestation or

contamination of the foods. We also found out of date food in the kitchen, for instance we found an item of food where the 'best before' date was four days prior to our inspection visit. This meant that people were placed at risk of eating food that was not suitable for consumption.

The above information was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although most people told us they felt safe at Victoria Cottage we found processes to protect people from abuse and improper treatment were not effective these were not always applied in practice. Although the training matrix showed staff and managers had received safeguarding training, we found evidence to demonstrate this had not provided staff or managers with adequate skill and competency to ensure people's safety. Consequently, we found evidence of a number of incidents that had not been formally investigated and had not been referred to the local authority safeguarding adults team. One person had sustained a serious injury and the circumstances were unclear; however, no referral had been made to the local authority safeguarding team to notify them of this serious injury. Another person had fallen out of bed, over their bedrails, and sustained a serious injury, again this had not been referred to the safeguarding adults team for further investigation.

The provider had not ensured effective systems were in place to investigate unexplained bruising or injuries to people living at the home. We reviewed incident records and found multiple records of unexplained injuries that gave us cause for concern, as there was no evidence of investigation or reporting. For example, a recent incident record for one person, documented they had 'finger print size' bruising to their body. This injury was unexplained and there were no records to demonstrate action had been taken to investigate the cause of this injury. A body map completed for another person documented they had bruising from their hand up to their elbow. Again, this was an unexplained injury. Neither of these injuries had been investigated or referred to the safeguarding adults team.

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

There were enough staff available to meet people's needs and ensure their safety. Feedback about staffing levels from people living at the home and their relatives was positive. One relative told us, "Staff are up straight away if [relation] presses their buzzer." All staff agreed there were enough staff to keep people safe and meet their needs. The manager explained they were using some temporary agency staff to cover some night shifts. They were in the process of recruiting new staff, which they told us would reduce agency usage. During our inspection, we saw people's needs were responded to quickly and there were staff available to give support throughout the day. We also observed that other staff, including domestic and housekeeping staff, helped out when needed. Staff rotas corresponded with the levels determined by the provider.

Safe recruitment practices were followed. The necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them. For example, before staff were employed, criminal records checks were undertaken through the Disclosure and Barring Service. These checks are used to assist employers to make safer recruitment decisions.

Other than the issues referred to above, we found people received their medicines as required. People told us they got their medicines when they needed them. Overall, medicines records were completed accurately to demonstrate that people had been given their medicines as prescribed. Staff had training in the safe management of medicines and their competency was checked regularly. Recent audits had been effective in identifying and addressing most areas for improvement.

People were protected from risks associated with the environment. There were systems in place to assess and ensure the safety of the service in areas such as fire and legionella. There were personal evacuation plans in place detailing how each person would need to be supported in the event of an emergency, such as a fire.

Requires Improvement

Is the service effective?

Our findings

People were not always supported by staff who had the skills and knowledge to provide safe and effective care and support. People told us they felt regular staff knew what they were doing, but added that agency staff did not always have the skills to provide safe support. Two people told us agency staff did not know how to use the moving and handling equipment and both said this had a negative impact on their health and wellbeing.

Although records showed regular staff had received a range of training such as safeguarding, health and safety and infection control, the training records for agency staff did not demonstrate they had the training required to provide safe care. Some agency staff did not have basic training, such as, safeguarding adults and infection control and others did not have practical training, such as, moving and handling. We discussed this with the manager who told us they thought agency staff did have training; they said they would contact the agency and inform us of the outcome. However, at the time of writing this report they had not informed us of the outcome. This failure to ensure all staff were sufficiently trained placed people at risk of harm.

In addition to the above, agency staff did not always have the required competency to deal with emergency situations. Incident records documented that one person had recently required emergency treatment at night. Agency staff on shift had not been able to communicate clearly with the person or the emergency services due to a language barrier. Consequently, their relative had been called to talk to the emergency services. This increased the person's distress. We also received concerns from the emergency services about the competency of staff in relation to another incident involving agency staff. Following a call out in April 2017 the ambulance service told us the night staff were unable to understand the crew, they had no knowledge of why ambulance had been called and were unable to locate important documents. The ambulance crew had to call the manager to improve communication. This meant staff did not always have the required competency to provide safe and effective support.

The majority of training for staff was online and some staff said they did not find this an effective way of learning. The manager was aware of this, but action had not been taken to improve the training available to staff. When staff had transferred from other roles within the home, they had not always been provided with adequate training to ensure they had the skills to undertake their new role. One member of staff had been promoted into a more senior role. Despite having had no previous experience in a senior role, they were not provided with any additional training to help them fulfil their duties effectively.

The above information was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above, staff told us they felt supported and records showed most had regular, supervisions to discuss any concerns and identify any training and development needs. We also found, staff had training in relation to people's individual needs. For example, staff had received training on a common eye condition experienced by older people; they knew who had difficulties with their eyesight and the impact of this upon

them.

People were not always protected from the risks of poor fluid intake. Fluid intake was not always appropriately monitored. For example, one person had been identified as being at risk of poor hydration and as a result the staff team were monitoring their fluid intake. However, the amount of fluid recorded on the fluid charts was not always added up, which meant staff were not calculating the person's total daily intake. This meant it would not be identified if the person had enough to drink. A recent fluid chart that stated that they received a total of 300mls in one day, which was significantly under the recommended amount. There was no evidence that action was taken to promote increased fluids. This placed people at risk of poor hydration.

Action had not always been taken to ensure staff had sufficient information to promote good nutritional intake. We observed one person did not eat any of their meal and records showed they routinely declined all meals offered to them. Their care plan had not been updated to reflect the fact they frequently declined to eat their meals and consequently there was no guidance for staff on how best to support them. The person had recently lost a significant amount of weight. The failure to consider people's individual needs placed people at risk of poor nutritional intake.

The above information was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living at the home gave mixed feedback about the food served at Victoria Cottage. Records of meetings showed that most people were very positive about the food. However, during our inspection, one person told us they did not feel their choices were catered for and another person explained they did not like some of the food so asked their family to bring food in for them.

During our inspection, we observed a mealtime and saw people were offered an adequately sized portion of home cooked food. People were provided with timely assistance when needed. People were provided with cold and hot drinks throughout the day. Records showed people were involved in making choices about what was on the menu, this was discussed in regular 'residents meetings' and the manager told us this information was then used to improve and update the menus.

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

People were involved in decisions about their care and support, and their rights under the MCA were protected. People's care plans contained clear information about whether or not people had the capacity to make their own decisions. Assessments of people's capacity in relation to specific decisions had been carried out when their ability to make their own decisions was in doubt. If the person had been assessed as not having capacity, a best interest's decision had been made and recorded and this was cross-referenced with the persons care plan ensuring the principles of the MCA were followed. For example, one person was unable to consent to a significant restriction upon their right to freedom. There was a clear and detailed assessment of their capacity and information about how the decision had been reached in the person's best interest. Where appropriate, people's families had been had been involved in making these decisions.

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. The manager had made applications for DoLS where appropriate. There were no conditions on any of the DoLS we reviewed.

People told us they were supported with their health and well-being and staff made contact with relevant healthcare professionals as needed. We saw evidence to demonstrate people were given support to attend regular appointments and to get their health checked. Staff sought advice from external professionals when people's health and support needs changed. Records showed referrals were made to external physical and mental health specialist teams when advice and support was needed. However, we received some feedback from an external health professional that staff sometimes lacked initiative and confidence in their own judgements about people's health needs. Care plans contained personalised and detailed information about people's health needs in order for staff to provide effective support. For example, one person had a condition and was prone to frequent infections, their care plan contained detailed information about this.

Information was shared across services when people moved between them. The provider assessed people's needs prior to them moving in to the home and this was then used to inform a care plan. In addition, the manager told us they used the 'red bag' scheme. This scheme is designed to share information and important items, such as medicines, between care homes and hospitals, to ensure care is person centred and effective.

The home was adapted to meet people's needs. Victoria Cottage is situated in a large converted residential premises. Consideration had been given to people's needs in the design and decoration of the building. For example, aids and equipment had been installed in some areas to enable people with mobility needs to navigate around the building and the provider had installed a call bell system to ensure people could request staff as required. There was a communal lounge and dining area on the ground floor and a separate activities and reminiscence room, which meant people had ample space to spend time socialising with friends and family. People's needs associated with dementia had been taken into account in the design and decoration of the environment. Dementia friendly signage was in some areas of the building and where required people had information displayed on their bedroom doors to help them identify their own bedroom.

Requires Improvement

Is the service caring?

Our findings

People did not consistently receive caring support. People and their relatives told us the permanent staff were kind and caring. During our inspection, we found staff were friendly and approachable, they responded to people with warmth, affection and compassion. People used terms such as "pleasant" and "helpful" to describe staff. A relative told us, "They (staff) are always kissing and hugging people." In contrast, people were less positive about the approach of temporary agency staff. One person told us, agency staff were often abrupt and appeared rushed, they said, "staff seem rushed, they don't stop and converse." They told us agency staff did not always know what they were doing and did not listen to them when they tried to tell them how they wanted to be assisted.

The language used by staff to describe people did not always promote their dignity. For example, during our inspection we heard a member of staff describe people who needed assistance to eat as, "The feeders." This language did not promote respectful, dignified support.

Staff did not always communicate with people and explain the support they were providing. During our inspection, there were some instances where staff did explain to people what was happening during transfers with hoists. Staff were assisting one person to move using the hoist, we saw they did not speak to the person until they were up in the air and they did not explain what they were doing when they tried to remove their sling from under them. On another occasion, a member of staff approached a person from behind and pulled them backwards in their wheelchair without any communication or warning.

On other occasions, we found staff were responsive to people's anxiety and distress and reacted quickly to put people at ease. For example, one person repeatedly sought reassurance from staff throughout the day, staff were patient and consistent in their approach and we saw this calmed the person and put them at ease. A staff member demonstrated insight into what could cause anxiety and distress for another person. The staff member explained how to reduce their anxiety, saying, "We communicate with them and distract them with another activity, talking about dinner works well." Another staff member explained how holding hands with a third person and complimenting them a lot made them more willing to accept personal care.

People told us they felt regular staff knew them well and people's care plans contained information about their background and their preferences. During our inspection, we observed staff had a good understanding of what mattered to each person and used this to inform their support. For example, we saw a member of staff laughing and joking with a person and their family over the football teams they supported; it was clear they know them well and had a good rapport.
People were supported to maintain relationships with friends and family, and people's friends and relatives were welcome to visit Victoria Cottage. There were no restrictions upon visitors to the home.

Staff had a good understanding of people's communication needs and used this to inform their support. Care plans contained information about people's communication needs and staff demonstrated a good knowledge of this. People were involved in day-to-day choices and decisions. During our inspection, we saw people were offered choice about what they ate and drank and where they spent their time and staff

respected their choices.

There was mixed feedback about whether people had been involved in their care plans. The manager told us people's care plans were developed using pre-admission assessments and people were offered the opportunity to be involved in regular reviews. However, this was not consistently supported by feedback from people. Some people informed us that they did not feel as though they had been actively involved in developing their care plan other than a short conversation when they first moved to the home. They could not recall seeing their care plan and had not been asked formally for feedback since moving in. In contrast, relatives felt involved in their loved one's care because staff kept them informed about concerns.

People had access to an advocate if they wished to use one. There was information about advocacy displayed in the service. Advocates are trained professionals who support, enable and empower people to speak up. No one was using an advocate at the time of our inspection.

Overall, people were supported to maintain their independence. People's care plans included information about areas where they were independent and where they needed support. For example, staff had developed prompts for one person to remind them how to use their remote control and had written a reminder of mealtimes that was kept next to the person's chair. This helped the person retain some aspects of their independence.

People's right to privacy was respected. One person told us staff always respected their wishes to use an upstairs bathroom because it gave them more privacy. Another person told us staff always covered them during personal care to protect their dignity and promote privacy. Staff had a good understanding of how to respect people's right to privacy and described actions such as covering people and ensuring doors were closed during personal care.

Requires Improvement

Is the service responsive?

Our findings

People were at risk of receiving inconsistent support that did not meet their needs. Each person living at the home had an individual care plan; however, the quality of the information contained in them were variable. Whilst some parts of care plans contained sufficient information, other parts lacked detail and had not been updated to accurately reflect changes people's needs. For example, one person's support needs had changed significantly in the weeks prior to our inspection but their care plan had not been amended to reflect this. This did not assure us that all staff had access to clear guidance to inform the support provided and placed people at risk of inconsistent support that did not meet their needs.

Care records did not evidence that people received appropriate care that met their needs. Personal care charts showed that people were not supported to have regular baths or showers and instead were provided with 'strip washes.' One person had no shower or bath recorded in April or May 2018, instead had daily 'strip washes'. There was no evidence the person had been offered, but declined, a bath or shower and their care plan did not contain any information to indicate they were reluctant to have a bath or shower. Another person had only had two showers in April and May; however, their care plan stated they 'enjoy a shower,' and a staff member told us that the person "Feels good when they have had a shower." People told us they were offered baths or showers once every two weeks. One person told us that generally they were okay with that, but also commented that when they asked for more frequent showers this had not been provided.

People's diverse needs had not always been identified and accommodated. We observed one person was struggling to locate their food and had to check with staff on multiple occasions about whether there was any food in their bowl. No consideration had been given to the impact of their dementia on their ability to eat a meal. They had not been provided with adapted crockery to improve their skills and build their independence. We discussed this with a staff member who told us they had different coloured crockery available but had not considered its use for this person or others who were also observed to be struggling.

The above information was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had been offered the opportunity to discuss their wishes for the end of their lives and this had been sensitively recorded in their care plans. Where people had made an advanced decision to refuse certain type of medical intervention this was clearly recorded in the care plan and the appropriate documentation had been correctly completed.

People's diverse needs in relation to their culture or religion were recognised and accommodated. The provider told us in the PIR that people's individual needs, in relation to areas such as culture and religion, were discussed as part of 'full detailed pre-admission assessments.' The manager told us that they were not supporting anyone with diverse needs at the time of our inspection, but added that they would identify and accommodate people's needs as and when required. The manager also told us that local religious leaders visited the home on a regular basis to ensure people's religious needs were met.

The management team explained how they met their duties under the Accessible Information Standard by providing information in different formats as required. The Accessible Information Standard ensures that all people, regardless of impairment or disability, have equal access to information about their care and support. The provider told us in the PIR that they discussed people's information access needs as part of care planning and then used this information to make adjustments to the service. They provided examples of using picture cards to enable people to makes choices about food and using subtitles to enable people with sensory impairments to watch the TV.

People were provided with opportunities for social activity. Activities were provided by staff on an individual basis in accordance with people's preferences. Throughout our inspection visit, we observed staff chatting with people and playing games. Staff were encouraging and friendly in their approach and people appeared to enjoy the interactions. There were also a range of organised events and entertainment options available to people, such as motivational exercise classes and creative sessions. People were given a choice about how they spent their time and their care plans included details of their hobbies and interests. For example one, person loved to read the paper and during our inspection we saw them enjoying doing so. An external health professional told us that staff were often playing games or chatting with people when they visited the home.

There were systems to record and handle concerns and complaints; however, these processes were not always followed and people's confidence in raising concerns and complaints was mixed. Whilst most people and their relatives told us they felt comfortable raising issues, some people commented they did not have confidence that complaints would handled sensitively. The manager told us there had not been any complaints since our last inspection. However, during our inspection one person and a relative told us they had previously made complaints and raised concerns about the service. Despite this, there were no formal written records of recent complaints and no evidence of action being taken to address concerns and complaints. This meant people could not be assured their complaints and concerns would be handled effectively.

Inadequate

Is the service well-led?

Our findings

Following concerns found at our inspections in 2016 and 2017 the provider had employed a consultant to support them to improve the quality of the service provided at Victoria Cottage Residential Home. During our last inspection in May 2017, we found this had had a positive impact. However, the consultant stopped working with the home in January 2018, and the registered manager left at the same time. During this inspection, we found this had resulted in a deterioration of the quality, safety and leadership of the service. Improvements made to care plans and risk assessments had not been sustained and there had been a failure to take action to protect people from abuse.

Systems to monitor and improve the quality of the service were not robust. Although there were processes in place to monitor the quality and safety of the service these were not always effective. Consequently, these systems had not identified all issues identified during this inspection. For example, a complaints audit had been conducted but had not identified that complaints had not been recorded. A cleaning audit had not picked up the issues we found with the cleanliness of the laundry room, consequently this remained a concern during our inspection. This failure to implement effective systems meant areas for improvement had not been identified or addressed.

Improvements had either not be made, or sustained, in response to known issues. For example, an audit had been conducted by the Local Authority in December 2017. This had identified the need for improvements in risk assessments, care planning, staff training, infection control and quality assurance. During our inspection, we found continued concerns in all of these areas. This failure to take effective action to address the issues resulted in continued concerns about the quality and safety of care and support and placed people at risk of harm.

Following our inspection the project manager provided us with an action plan detailing actions planned. However, the action plan was not specific and lacked details about planned timescales for action. For example, one action stated, 'undertake new risk assessments for any areas identified by care plan reviews'; however, it did not state when this would be achieved or provide any assurances about how the immediate risks to people identified during our inspection, such as choking risk, would be addressed. This meant risks to people's health and safety may not be prioritised and addressed in a timely manner.

The system for analysing, investigating and learning from accidents and incidents was not robust. Although an audit system was in place that checked that immediate action had been taken after incidents, such as falls or injuries. Trends of accidents and incidents, such as the location or timing, were not analysed. This failure to fully analyse accidents and incidents meant that opportunities may have been missed to identify ways of preventing future incidents, and exposed people to the unnecessary risk of potential harm and injury. This meant we could not be assured all reasonable steps had been taken to improve the quality and safety of the service.

Records of care and support were not accurate or up to date and staff did not always have access to clear information about the people they were supporting. Care plans were not an accurate reflection of people's

need and, records of care and support, such as food records, were not fully completed. The failure to ensure records were complete and up to date meant the provider was unable to demonstrate people had received the care and support they required. Furthermore, systems to audit care plans were not effective. For example, we reviewed one care plan and found it did not contain sufficient information about risk management or about how to support the person if they became anxious or distressed. This care plan had been audited a few weeks before our inspection and no areas for improvement had been identified. An audit of another care plan, conducted three weeks prior to our inspection, had identified a number of areas for improvement, such as the need to conduct up to date risk assessments. During our inspection, we found these areas from improvement had not been addressed. The lack of effective systems to check on the quality and consistency of care plans meant there was a risk that people's care was not being delivered safely and in line with the regulations.

Sensitive confidential information about people who used the service was not always stored securely. During our inspection visit, we observed that that records of people's care and support and people's personal correspondence including, bank statements and letters, were kept in an unlocked cupboard in the communal lounge. There was no lock on the door, which posed a risk that this information could be accessed by people who used the service or visitors.

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

The provider had not ensured that we were notified of incidents at the service, which they are required to by law. A notification is information about important events, which the provider is required to send us by law such as serious injuries and allegations of abuse. We identified the provider had not informed us of two serious injuries to people living at Victoria Cottage Residential Home. A failure to make notifications as required, impacts upon our ability to monitor the service.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and online where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their most recent rating on their website. However, this was not displayed conspicuously in the home. We shared this feedback with them and they told us they would ensure the rating was displayed as required.

Despite the concerns identified during our inspection visit, people and their relatives were positive about Victoria Cottage Residential Home and said that they felt the home had a good atmosphere. A relative told us, "I have no regrets about [relation] coming here."

Staff felt supported in their roles and told us the management team were approachable. Staff were able to offer feedback on the service in a number of ways including in supervision meetings and team meetings. Records showed that staff meetings took place regularly and were used to address issues and share information. Staff were aware of their duty to whistleblow about poor practice and felt confident in raising any concerns with the manager.

People who used the service and their families had the opportunity to be involved in some aspects of the running of the home such as the food, activities and events. Meetings were held for people and their representatives, although these had been infrequent. Records of the most recent meeting showed these were used to discuss entertainment, food and gave people the opportunity to raise any concerns or

complaints. The provider also asked people to complete regular surveys on the quality on the service provided. This showed us that there were systems in place to collate feedback from people and the provider was using these to drive improvements.

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	Regulation 18 Registration Regulations 2009 Notifications of other incidents The commission was not notified of serious injuries as required. Regulation 18 (1) (2)

The enforcement action we took:

We took action to remove the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not provided with person centre care that met their needs and reflected their preferences. Regulation 9 (1)

The enforcement action we took:

We took action to remove the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not identified or managed and this exposed people to the risk of harm. Regulation 12 (1) (2)

The enforcement action we took:

We took action to remove the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not adequately protected from abuse

	and improper treatment. Regulation 13 (1) (2) (3)

The enforcement action we took:

We took action to remove the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to ensure the quality and safety of the home were not effective. Regulation 17 (1) (2)

The enforcement action we took:

We took action to remove the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always have appropriate training to enable them to carry out their jobs safely and effectively. Regulation 18 (1) (2)

The enforcement action we took:

We took action to remove the location