HC-One Limited

Victoria Park

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 4 February 2015 and was unannounced.

Victoria Park provies accommodation, personal care and support to older people. It is registered to accommodate a maximum of 32 people. At the time of our visit there were 26 people living there. The accommodation is set out over two floors with a lounge and dining area on each floor.

The home had a registered manager in post who was present for our inspection. 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. The registered manager had been in post for five weeks.

People and staff told us that due to staffing levels there was sometimes a delay in responding to people's needs. During our visit we observed occasions when people had to wait for support after requesting assistance.

The Mental Capacity Act 2005 (MCA) sets out how to support people who do not have capacity to make a specific decision. Where there were doubts

Summary of findings

about people's capacity to make specific decisions, capacity assessments had not been completed. We have made a recommendation that the provider should seek advice about capacity assessments.

People told us they felt safe living at Victoria Park and staff knew how to protect people against the risk of abuse. Staff understood how to keep people safe and that any concerns should be reported to the manager. There was detailed information for staff about how to manage identified risks to people, but we found this was not always being carried out in practice. The provider had plans to ensure people were kept safe in the event of an emergency or unforeseen situation.

We found staff missed opportunities to engage with people when delivering care and support. There was no activities co-ordinator in post at the time of our visit so people's social needs were not being met. Staff were provided with information so they could be supportive of people's spiritual and cultural needs. Family and friends were able to visit at any time of the day.

Care plans were very detailed about people's routines and how they preferred their care and support to be provided by staff. Staff had a good knowledge of the people they were caring for, but did not always deliver care in accordance with people's preferences.

People were supported to eat and drink enough to maintain their health and well-being and to attend appointments with external healthcare professionals.

There was a new management team in post. The new manager had already identified areas that required improvement and staff told us they found her open, available and responsive.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 consistently safe.

People told us they felt safe with care staff but there were sometimes delays in meeting people's needs when staff were busy and could not respond promptly. Staff understood how to manage risks but this was not always carried out in practice. People received their medicines as prescribed.

Requires Improvement

Is the service effective?
The service was not consistently effective.

Staff had completed essential training to meet people's needs. Where there were doubts about people's capacity to make specific decisions, assessments had not been completed. People were supported to maintain their health and referred to external healthcare professionals when a need was identified.

Requires Improvement

Is the service caring?
The service was not consistently caring.

Staff did not rush people when providing support, but opportunities to chat and engage with people were missed. Relatives and friends were able to visit at any time of the day.

Requires Improvement

Is the service responsive?
The service was not consistently responsive.

Staff had a good knowledge of the needs of the people they were caring for, but did not always deliver care in accordance with people's preferences. The service was not responsive to people's social needs.

Requires Improvement

Is the service well-led?
The service was not consistently well-led.

A new management team was in place at the time of our visit. Some checks and audits on the quality of service provision had not taken place during the period between the previous manager leaving and the new manager arriving. The new manager had identified areas where improvements were needed and staff found them open and responsive.

Requires Improvement

Victoria Park

Detailed findings

Background to this inspection

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

This inspection took place on 4 February 2015 and was unannounced.

The inspection team consisted of two inspectors and an expert by experience. The expert by experience was a person who had personal experience of caring for someone who had similar care needs.

We reviewed the information we held about the service. We looked at information received from relatives and other agencies involved in people's care. We looked at the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We also contacted the local authority contract monitoring officer. They had no new information to share with us.

We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what their service does well and improvements they plan to make.

During our inspection visit we spoke with the registered manager, seven care staff and two non-care staff. We spoke with six people who lived at the home and four relatives and observed how people received their care from staff.

We looked at a range of records about people's care and how the home was managed. We looked at care records for four people to see how they were cared for and supported. We looked at other records related to people's care including medication records, records of complaints and incidents and accidents at the home and records relating to staff.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they sometimes had to wait for staff to give them support or assistance. One person told us, "The other day I waited two hours to go to bed in the afternoon. I waited and waited." Another person told us of a time when they required support with personal care. A member of staff told them they needed another member of staff to assist. The person waited an hour before two staff returned. They went on to say, "They [staff] are caring but they are too busy. The maintenance man hoisted me the other day." A relative told us, "[Person] does sometimes smell. My biggest concern here is they do not have enough baths, sometimes goes a week. Just awful they can't have more but there is not enough staff." We asked one person what they would improve in the home. They responded, "The waiting time."

All the staff we spoke with felt there were not enough staff available to meet people's needs. Comments included: "There is a bit of the job that frustrates me when the bell is going and I am with someone else and the senior is doing the medication. It frustrates me I have to leave the person or have to let the other person wait." "When [the senior is] doing medicines, if one of the double ups needs help it is so difficult. On each floor there are two staff so the senior has to finish what they are doing to help. This happens frequently." "We can be in a room hoisting someone and the buzzer goes off and we have to leave one carer with the hoist while we go and check the other one. I think there should be extra staff to cover for this reason. It happens quite a lot."

We were told staffing levels during the day were one senior and one care worker on each floor. Eight people in the home needed two staff when receiving care and support. The senior members of staff administered the medicines for the floor they were working on. During the morning of our visit we observed two people waited over half an hour to be supported to the toilet after they had asked for assistance from staff. Staff told us they had to make choices about what they needed to do first and accept some people would have to wait before assistance could be provided.

We asked staff how they kept people safe in the communal areas if they were providing care in people's bedrooms. They explained, "We do 15 minute checks even when we are busy." We found that records of the 15 minute checks were sometimes completed retrospectively which indicated they were not always being carried out as planned.

We found this was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Staffing

People told us they felt safe at Victoria Park and thought their possessions were safe in their rooms. Responses included: "I feel safe here but there is nowhere else to go." "Yes I feel very safe." "Nothing to be afraid of, all my things are safe. I would soon let them know."

Staff understood their role in keeping people safe and told us they would report any concerns to the registered manager. A staff member described one form of abuse as, "Not giving a choice, taking control away from them, their independence." Staff also understood how to report accidents and incidents and told us they would record any wounds or bruises on body maps. The service had a whistleblowing policy and dedicated whistleblowing line for staff to contact if they had any concerns they could not raise directly with the registered manager. We asked staff if they thought people were safe. One staff member responded, "I think they are but I think they would be safer if we had extra staff."

There was a system in place to make sure care staff were recruited appropriately and to ensure they were safe to work with people who used the service.

People told us they had help from staff to take their medicines and that they received them on time. We looked at how medicines were managed in the home. Medicines were stored in accordance with good practice. People's medicine administration records (MARs) were complete and up to date which showed they received their medicines as prescribed. Some people were prescribed medicines "as needed". There was clear information in place for staff to follow which helped them to administer these medicines safely and consistently. This is particularly important when people are unable to communicate their needs. The staff member who took us through the medicine management process demonstrated a good awareness of people's medication needs.

Risk assessments identified potential risks associated with people's care. We looked at the care plan for one person who was at high risk of falls and also developing sore areas

Requires Improvement

Is the service safe?

on their skin. All the appropriate equipment was in place to keep that person safe. This included pressure relieving equipment and an alert mat on their chair so staff would be aware if they attempted to move without assistance. Some people who were unable to reach a call bell also had neck pendants to call staff if they got into difficulties.

Equipment was in place to support staff in moving people safely. There was good information for staff about the checks to make before using equipment to ensure it was safe to use. However, one person told us of an occasion when they were being hoisted and had been left "dangling in mid-air" as the battery had run out. Communal areas were clear of trip hazards and chairs and tables were positioned so people had clear access to walk around them.

Staff we spoke with understood how to manage risks, but we found this was not always being carried out in practice. Records told us one person needed to be re-positioned every two hours so the risk of them developing skin damage was minimised. They also required regular support with personal care. The person was sat in the communal lounge during our inspection. We saw the person was not repositioned between 9.45am and 4.30pm and did not receive any personal care. We brought this issue to the attention of the manager during our inspection who then organised members of staff to assist the person to reposition. This lack of movement and personal care posed a risk to the person as they were not receiving the care and support they required.

There was a maintenance schedule in place to make sure the environment was safe and equipment was kept in good working order. This included a system of internal inspections of equipment and maintenance by external contractors.

The provider had plans to ensure people were kept safe in the event of an emergency or unforeseen situation. Emergency equipment was checked regularly. There was a central record of what support each person required to keep them safe if the building had to be evacuated. The record was accessible to the emergency services. Staff we spoke were aware of the emergency plans, particularly in the event of a fire.

Requires Improvement

Is the service effective?

Our findings

Staff told us they received training considered essential to meet the needs of people safely and effectively, most of it through computer e-learning. Records confirmed nearly all the staff were up to date with their essential training. One staff member told us, "The training is good and they are always on our cases to keep up to date with the touch [computer] training." However, all the staff spoke about the pressures of completing training during the working day and some staff completed it at home.

We asked staff if they had received training to support them meet the specific needs of people who lived in the home such as diabetes. A typical response was, "We don't have time to go on training courses because we are always short staffed so we are always covering shifts."

The registered manager acknowledged that some improvements needed to be made in the delivery of training. They explained, "Training is a great deal of e-learning. The reality is it is difficult for them to do that on shift. We need to be more diligent to make time on a shift for them to do the modules."

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find.

The MCA protects people who lack capacity to make certain decisions because of illness or disability. DoLS is a law that requires assessment and authorisation if a person lacks mental capacity and needs to have their freedom restricted to keep them safe.

The front door to the home was locked and people could only leave by using a keypad. We were told people did not have the code to the keypad and most were unable to leave the home unsupervised because they were frail, or it was considered unsafe. Where there was doubt that a person had the capacity to make a decision to leave the home unsupervised, this had not been assessed to make sure they were able to make the decision or establish whether a best interests decision was necessary. Where people had capacity to make decisions, they had not been consulted on whether they would want to leave the home, or how they could leave the home if they chose to. The registered manager said they would ensure the appropriate assessments were carried out to ensure people continued to live their lives safely and in the least restrictive way.

Most people ate lunch in the dining areas. People were given a choice of meals and drinks. If people did not like what was on the menu they could request another choice. The cook was aware of people's special dietary needs including those with allergies and those who were diabetic. People's cultural needs were provided for with different choices of meals offered. One person told us they enjoyed their food saying, "I like it, it's quite good. It isn't perfect but it is nice."

During the day we saw people were offered drinks and snacks between meals and jugs of squash and cartons of juice were available in lounge areas. A notice in the entrance hall reminded people that hot and cold drinks and snacks were available at any time of day or night. In communal areas there were plenty of side tables and overlap tables so people could readily reach their drinks. Records showed that water jugs were replaced in people's bedrooms daily. One person told us, "They are filling up our glasses all day long."

Some people in the home were on food and fluid charts because they were at risk of malnutrition or dehydration. The charts were completed in detail but we could not be certain they were always accurate as they were sometimes completed retrospectively. For example, at 2.15pm the records indicated people had not had anything to eat or drink since 10.30am. We knew this was not correct as we had observed people consuming food and fluid during our inspection.

Where there were changes in people's health, they were referred to the relevant healthcare professionals such as the GP, continence nurse and optician. The district nurse attended the home on the day of our visit to attend one person and another person was accompanied to a hospital visit by a member of staff.

We recommend the provider seeks advice and guidance in relation to assessment of mental capacity and best interest decisions.

Requires Improvement

Is the service caring?

Our findings

People told us staff were caring, but very busy. Comments included: “Very good, very caring. I don’t know how they put up with me” and “Staff interaction can be good but usually they are too busy.”

We asked staff whether they thought the service was caring. They responded, “I think it is good but sometimes we don’t have time to spend with people” and “I would like to spend more time as a carer with people in their room. Go in for five or 15 minutes and have a chat with them and do something worthwhile.” A member of non-care staff told us, “The staff are very kind, considerate and thoughtful towards the residents.”

We observed staff were busy, but they did not rush people when they were providing care and support. However, there were many missed opportunities for staff to engage with people and interaction between staff and the people living at the home was limited. At meal times we saw very little conversation. For example, one person was assisted to eat. The member of staff did not explain what was on the spoon and there was no enquiry as to whether the person liked what was being offered or whether it was the right temperature. There was little verbal communication from a member of staff who was serving morning drinks and biscuits. One member of staff sat in the lounge completing records with their back to the people sitting there.

During the day we saw people were offered choices about what they wanted to eat and drink and most people were able to choose where they wanted to spend their time. However, we observed one person who was unable to move independently ask to return to their bedroom. The person was still sitting in the lounge six hours later.

People’s care plans contained information about how staff should deliver care and support in a way that promoted people’s privacy and dignity. We observed staff carrying this out in practice. For example, asking people quietly if they needed assistance to the toilet. However, we received inconsistent responses when we asked people if they thought their privacy and dignity was always respected. One person told us, “When staff help me with my bath the assistance is good and they do show me privacy and dignity.” One person told us, “Most of them do.”

The provider was supportive of people with specific cultural and spiritual needs. There was information so staff could understand and respect those needs and provide the privacy people required, for example to follow their religious faith.

Relatives and friends were able to visit the home at any time of the day. There was a small area off the main corridor with a telephone with large numbers so people could maintain contact with family and friends independently and with privacy.

Requires Improvement

Is the service responsive?

Our findings

We found the service was not responsive to people's social needs. When asked what people did all day they responded: "Just sit here all day." "I can't watch television because my eyes are not good, I used to like reading." "Nothing happens anymore." "I get fed up." "I get bored, a man came last week and he sang and he was very good."

We were told the activities co-ordinator had recently changed their role and the provider was currently recruiting to the post. During our visit there were no activities taking place which left people sitting for long periods of time with just the television to entertain them. On the first floor the television was on a low sound setting and had been on the same channel all day. When we asked people if they wanted it louder, they told us they were not interested in the television. There was limited social interaction between people.

Staff told us people had not had the benefit of social activities for several weeks. One staff member told us, "We don't have activities at the moment. It isn't the best." "In the morning we don't have any activities. Those people need to do more. We need entertainment for them otherwise its boring for them." One person told a member of staff they felt tired. The member of staff responded, "Are you tired or just bored."

Care plans were very detailed about people's routines and how they preferred their care and support to be provided by staff. However, we found staff did not always deliver care in accordance with people's preferences. For example, one person's care plan stated they liked to be woken at 7.30am and then stay in bed watching television with a cup of tea. The person preferred their own company and liked to eat in their room, but would go to the lounge for a couple of hours each morning. Records showed that on the day of our visit and the previous two days they had been taken to the lounge at around 6.00am and stayed there until early evening. Staff had given the person their meals in the lounge.

We found some people's care needs had changed completely from when the care plan had been written. This was reflected in regular reviews but the care plan had not been amended. This made it difficult to get a clear picture of the person's current needs to make sure they were receiving the right support. However, staff we spoke with had a good knowledge of the people they were caring for and were able to tell us about their needs and how they supported them. One person had recently had a "pressure sore" but this was recorded as fully healed which suggested they had received the care required to promote healing.

There was information in the entrance to the home telling people about how they could raise a complaint following the provider's complaints procedure. There was also information about external organisations people could approach if they were not happy with how their complaint had been responded to. The complaints log confirmed that any complaints received had been responded to promptly and in accordance with the complaints policy.

All the people we spoke with told us they were able to tell a member of staff should they have any concerns. We asked staff how they would respond if anyone raised a concern with them. One staff member told us, "I would try and sort it out or if I couldn't sort it out I would ask the manager." Another told us, "I would take the complaint to the senior and the senior would go and talk to them or go to the office."

Requires Improvement

Is the service well-led?

Our findings

The registered manager was new to the home and had been in post for five weeks at the time of our inspection. They were going through an induction into the organisation. A member of staff had transferred from another home in the provider group as deputy manager. Although they had only been in post for a week, they had the benefit of already being familiar with the provider's policies and procedures. The registered manager told us, "[Deputy manager] coming over has been very helpful. She is on the floor and knows systems and she can report back to me. She has already identified things we need to work on."

During the interim period between the previous registered manager leaving in October 2014 and the new registered manager starting in January 2015, a registered manager from another home in the provider group had provided managerial oversight. Staff we spoke with told us they had felt supported during this period. One staff member said, "If there was anything you couldn't do or were struggling with it was quite good." However, it was clear some of the provider's usual checks, audits and meetings had not taken place during the interim period. For example, staff supervision meetings, the manager's daily checks around the home and health and safety meetings had not taken place since the previous registered manager left. As a result, the issues we saw during our visit had not been identified.

Staff told us they had regular staff meetings where they were able to voice their opinions, but they did not feel that action had always been taken to address their issues. For example concerns around staffing. Staff told us they had raised the issue numerous times but, "All they say is it is a residential home and the staff level is okay."

However, staff told us they felt positive about the new manager and found her open, available and responsive. Comments included: "[The manager] is lovely. She has a lot of knowledge from the outside because her background is social care." "The new manager has some good ideas but they have only been here a few weeks." "She is willing to listen to us which is a good thing. She has asked us if there is anything we think should change. She was in her office at the beginning but she comes out every day and asks if there is anything we need help with." We discussed with one staff member the fact they were working double shifts which meant they were working 14.5 hours at a time. They told us, "Everybody wants 12 hour shifts but we have a new manager and she has put into HR to get them changed."

During our discussions with the new registered manager, it was clear they had already identified areas where improvements needed to be made. For example, they acknowledged improvements needed to be made in the provision of training within the home. They wanted to introduce better systems to ensure staff understanding of training so they could effectively carry it out in their every day practice. They told us, "I would be looking to see how training is carried out on a practical nature and follow up in supervision. I need to understand where everyone is with their training. I'm used to workshops and practical things and would like to develop that here." They also explained they wanted to make sure staff were aware of their roles and responsibilities within the home to ensure things were not missed and shifts ran effectively.

The provider had recently agreed to take discharges from the local hospital as enablement packages to get people back on their feet before returning to their homes. We were concerned the provider had not assessed how these short term admissions would place extra demands on the home or explored how they were going to be managed on current staffing levels. The manager assured us they would keep the situation under review and liaise with the provider if it was identified that extra staff were required to manage the new admissions. They explained, "I feel comfortable with the assessment and theory, but it's the impact it has on the running of the home."

We asked the manager what their vision was for the home. They responded, " I understand all the routine things need to be done but I don't want it to be a home just going through the motions. I would like it to be more personal for the residents. We are not a dementia home so we should have people who can engage and I don't think that is being done."

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing There were not always sufficient staff with the right knowledge, experience, qualifications and skills to support people.