Mrs Saima Raja

Victoria Lodge Residential Care Home

Inspection report

138 Thorne Road
Edenthorpe
Doncaster
South Yorkshire
DN3 2LU

Tel: 01302884806
Website: www.braemarcare.co.uk

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	Requires Improvement
Is the service effective?	Inadequate
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Summary of findings

Overall summary

The inspection was unannounced, and took place on 15 December 2016. The previous inspection had taken place in July 2016, with other inspections taking place in January 2016 and February 2016. At each of these inspections a number of breaches were identified. Following the inspection in July 2016 we judged the overall rating of the service to be Inadequate. We are currently taking enforcement action against the provider and will report on this at a later date. You can read the reports from our previous inspections, by selecting the 'all reports' link for Victoria lodge on our website at www.cqc.org.uk

We have placed the service into special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

Victoria Lodge Residential Home is a care home providing accommodation for older people who require personal care. It also accommodates people who have a diagnosis of dementia and can accommodate up to 24 people. At the time of the inspection there were ten people using the service. The service is situated in Edenthorpe near Doncaster, close to local amenities and public transport links.

The registered manager had left their post in June 2016. A new manager had been recruited in July 2016, and both the new manager and the provider gave CQC assurances that this manager would have begun their application process to register with CQC by August 2016. However, at the time of the inspection in December 2016 they had failed to commence this process. 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 and associated Regulations about how the service is run.

During the inspection we found that staff appeared to know people and their needs and preferences well, but failed to ensure people's dignity and privacy was always upheld.

The provider was failing to act in accordance with the requirements of the Mental Capacity Act and was not taking the legally required steps where people lacked the capacity to consent to their care.

Peope told us they enjoyed the food at the home, but we found that food was not served or stored safely, and people's needs in relation to food were not always met.

There was an audit system in place but it was ineffective as it did not identify shortfalls in the quality, safety or effectiveness of the service provided.

We found that the management of medicines had improved, as had the way staff supported people to move

around the home, although further improvements were required.

We checked people's care plans and risk assessments and identified that where people were at risk of harm, the provider was not taking appropriate steps to reduce the risk.

The provider ensured that people had access to external healthcare providers where required, and regularly reviewed people's care. However, the reviews were not always effective as they didn't effect the required changes.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

We found that the management of medicines had improved, as had the way staff supported people to move around the home, although further improvements were required.

We checked people's care plans and risk assessments and identified that where people were at risk of harm, the provider was not taking appropriate steps to reduce the risk.

Is the service effective?

Inadequate

The service was not effective

The provider was failing to act in accordance with the requirements of the Mental Capacity Act and was not taking the legally required steps where people lacked the capacity to consent to their care.

Peope told us they enjoyed the food at the home, but we found that food was not served or stored safely, and people's needs in relation to food were not always met.

Is the service caring?

Requires Improvement

The service was not always caring

Staff appeared to know people and their needs and preferences well, but failed to ensure people's dignity and privacy was always upheld.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The provider ensured that people had access to external healthcare providers where required, and regularly reviewed people's care. However, the reviews were not always effective as they didn't effect the required changes.

Is the service well-led?

Inadequate

The service was not well led.

The home's manager had not registered with CQC despite being in post for six months, and required notifications were not always made to CQC. The provider and the home's manager did not have the knowledge to effectively recognise or address breaches of regulation.

There was an audit system in place but it was ineffective as it did not identify shortfalls in the quality, safety or effectiveness of the service provided.

Victoria Lodge Residential Care 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 checked 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.

The inspection was unannounced, which meant that the home's management, staff and people using the service did not know the inspection was going to take place. The inspection visit took place on 15 December 2016. The inspection was carried out by two adult social care inspectors and a specialist pharmacist inspector.

During the inspection we spoke with staff, the home's manager, and people who were using the service. We checked people's personal records and records relating to the management of the home. We looked at team meeting minutes, training records, medication records and records of quality and monitoring audits.

We observed care taking place in the home, and observed staff undertaking various activities, including handling medication, supporting people to eat and using specific pieces of equipment to support people's mobility. In addition to this, we undertook a Short Observation Framework for Inspection (SOFI) SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Prior to the inspection, we reviewed records we hold about the provider and the location, including notifications that the provider had submitted to us, as required by law, to tell us about certain incidents within the home. We also contacted the local authority to obtain their views about the service.

Requires Improvement

Is the service safe?

Our findings

When we inspected the home in July 2016, we found concerns in relation to the service's safety. Moving and handling techniques were not always safe, improvements were required in relation to the way medicines were managed and risk assessment and risk management was not fit for purpose. We judged that the service required improvement for the domain of "safe"

At the inspection of December 2016, we reviewed information we held about accidents and incidents which had occurred in the home, and cross-checked this with people's records. We found that the provider was not taking the steps it said it would take when accidents or incidents had occurred. For example, one person had sustained an injury the month prior to the inspection, which was thought to be related to how they slept. When the provider notified CQC about the injury, they stated that the person's sleep care plan would be altered in order to reduce the risk of further harm. We checked their file but found that their care plans and risk assessments in relation to sleep had not been updated following the injury. The home's manager told us they believed this had taken place, however they checked the person's file and agreed with us that the required changes had not been implemented.

Another person had experienced a fall several weeks prior to the inspection. When the provider notified CQC about the fall, the notification form stated that in order to reduce risk the person would receive 15 minute checks. We checked the person's records, but found that there was no information stating that staff should carry out these checks. We asked the home's manager about this and they told us the checks had only taken place for a 72 hour period after the fall. It was unclear why the provider had told CQC that it was taking steps to reduce risk which it had not actually taken.

We observed staff undertaking moving and handling techniques to assist people to move around the home. We saw this had improved since our last inspection, and staff were taking steps to assist people to move safely. However, we identified that some concerns remained. For example, one person's care plan stated that they should be supported to move with the assistance of a "Rotunda" aid, which is a piece of equipment with a revolving base to assist people to move from one chair to another, for example from a wheelchair to an arm chair. We observed staff supporting this person and saw that they assisted the person to transfer from one chair to another using a frame rather than a Rotunda. The frame did not have a rotating base, meaning that the person was required to make additional movements during the transfer process.

We observed staff using a hoist to assist people to transfer from one chair to another. They ensured that they gave people reassurance and took time to undertake the process to reduce any distress to the person. However, we noted that they did not always prepare the area properly, meaning that the distance in which the person travelled in the hoist was further than should have been required, increasing the risk of them tipping. We cross checked the slings we observed used for people with their care records. We noted that for one person, the sling type used had been approved by a visiting occupational therapist and details of the sling type had been added to their risk assessment. However, their care plan had not been updated to reflect this, meaning that there was a risk that an incorrect sling could be used, putting the person at risk of

injury.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Training records showed that staff had received training in relation to the safeguarding of vulnerable adults, and staff we spoke with showed a good understanding of this area. One staff member we spoke with had only been in post for a very short amount of time at the time of the inspection, however, they could confirm that they had received safeguarding training as part of their induction before they began working at the home.

We looked at the recruitment procedures at the home to check that they ensured that people were kept safe. Staff we spoke with told us they had undergone Disclosure and Barring Service (DBS) checks before they commenced work. The DBS check helps employers make safer recruitment decisions in preventing unsuitable people from working with children or vulnerable adults. This helped to reduce the risk of the registered provider employing a person who may be a risk to vulnerable adults. We checked a sample of four staff members files We found that references and ID checks were in place in addition to DBS checks, although we noted that one staff member's records did not evidence their reason for leaving previous care posts.

We checked arrangements for the management of medicines at the home. We looked at records for seven people and spoke with the deputy manager who was responsible for giving medicines, as well as the manager.

Medicines were stored safely and securely and access to them was restricted to authorised staff. The home had appropriate arrangements in place for the management of controlled drugs (medicines which require special checks and storage arrangements because of their potential for misuse) and medicines requiring refrigeration, however there were no such medicines being stored at the home on the day of our inspection.

All of the records we reviewed contained a photograph of the person concerned and included their allergy status. This reduces the risk of medicines being given to the wrong person, or to someone with an allergy.

Some people were prescribed 'when required' medicines, and had person-centred protocols in place detailing when and how they should be used. However, there was no protocol in place for one of the people we reviewed who was prescribed a medicine used for agitation. In addition, we found staff did not record the reasons for administration or the outcome after giving the medicine, so it was not possible to tell whether medicines had had the desired effect.

We checked records for four people who were prescribed topical medicines (creams and ointments) and found staff did not accurately record when these had been applied on the Topical Medicines Administration Record (TMAR). In addition, TMARs did not correspond with the number of applications which had been signed for on the MAR. There was a lack of clarity over how often some of these creams should be applied. For example, three people were prescribed creams to be applied "frequently several times throughout the day", however we saw these had only been applied once or twice daily. The manager told us they would contact the doctor to confirm how often these creams should be applied and update their records accordingly.

We checked staff training files and found senior care staff had undertaken safe medicines administration training within the last 12 months. These staff had also received recent assessments of their competency,

carried out by the home manager.

The manager showed us weekly medicines audits, and we saw examples of how these were used to monitor stock balances, expiry dates, and gaps in administration records. However, the audits were lacking in scope and detail because they did not include all aspects of medicines management. The manager also showed us records of additional checks on the quantities of 'when required' medicines and inhalers which were carried out twice daily to ensure there were sufficient quantities to meet the needs of people using the service.

Inadequate

Is the service effective?

Our findings

When we inspected the home in July 2016, we identified concerns and breaches of regulation in relation to the domain of "effective" and judged that the provider was inadequate in this domain. We found that the provider was failing to ensure they obtained informed consent from people in relation to their care and treatment. Where people lacked the capacity to give informed consent, the provider did not follow appropriate procedures.

When we inspected the home in July 2016, we found that some staff required training in relation to the Mental Capacity Act and the Deprivation of Liberty Safeguards, and the provider was failing to comply with the requirements set out in law in relation to this. The training records we checked at this inspection showed that all relevant staff had now received Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) training within the preceding two years. 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. 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 looked at the arrangements in place for complying with the requirements of the MCA and DoLS, but found that the provider was still failing to comply with the law in this area. One person had recently received day care services at the home. Their assessment showed that they had the mental capacity to consent to their care. However, the home's manager had told us that they intended to apply to deprive the person of their liberty. We asked the home's manager why they thought they could legally deprive a person of their liberty when they did not lack capacity. They told us that they were "a bit confused" about the requirements of the law. Our conversations with them showed they lacked understanding despite having recently undertaken relevant training. The local authority also told us that they believed the home needed to make improvements in relation to their compliance with the MCA and DoLS

Some of the care plans we looked at showed that the person concerned lacked the mental capacity to consent to their care and support. However, the provider had failed to act in accordance with the law in these matters. For example, one person's care plan contained an assessment which showed that they lacked mental capacity and therefore could not make decisions about their care. Their file contained a "consent" form which was unsigned, stating that another person could give consent to the person receiving care. There was a note attached to the form stating that the home's manager needed to sign the consent form. The law in this situation does not allow for another person to give consent to an adult receiving care, and the home's managr had no authority to provide this "consent." Instead the provider should evidence how decisions about how the person should receive care had been reached and judged to be in their best interest, and who had been involved in the decision making process. The provider had failed to do this.

Another person's file contained an assessment showing that they lacked the capacity to give consent to the way they were cared for or make decisions about their care. Their file contained a number of care plans, setting out how the person should be cared for and how staff should meet the person's needs. Each of these had been signed by the home's deputy manager. Their file contained no information about how any decisions had been reached about the person's care, or who had been consulted to show that these decisions were considered to be in the person's best interest.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We asked three people using the service about the food available in the home. They told us that they enjoyed the food and that meals were always good. We observed a meal time taking place in the home, and found that staff worked to ensure that the environment was pleasant and calm. Where people required specialist equipment to enable them to eat independently this was provided, and where people needed assistance from staff this was done discreetly and respectfully. We did note, however, that staff did not always ensure good hand hygiene standards were followed when handling food.

We checked five people's care records to look at information about their dietary needs and food preferences. The files we checked contained details of people's nutritional needs and preferences. The care plans contained monitoring tools which checked whether people were at risk of malnutrition or dehydration, although it was not clear that these had been accurately completed. For example, one person's review records showed that they had lost almost five kilograms in the preceding four months, but their body mass index was recorded as not changing. In another part of their file there were also weight records which contradicted the weights recorded in the review records. This meant it was unclear which records were accurate, or how the person's health could be appropriately monitored. Another person's assessment stated that they should be weighed weekly in order for the provider to monitor their health. However, we saw that they were not being weighed at this frequency meaning that it was unclear how the provider was monitoring their wellbeing.

One person's eating and drinking care plan stated that they were vegetarian. The Vegetarian Society defines a vegetarian as "someone who lives on a diet of grains, pulses, legumes, nuts, seeds, vegetables, fruits, fungi, algae, yeast and/or some other non-animal-based foods (e.g. salt) with, or without, dairy products, honey and/or eggs. A vegetarian does not eat foods that consist of, or have been produced with the aid of products consisting of or created from, any part of the body of a living or dead animal. This includes meat, poultry, fish, shellfish, insects, by-products of slaughter or any food made with processing aids created from these." We asked the home's cook what that person's lunch would consist of on the day of the inspection. They replied that one of the day's options was liver in gravy with potatoes and vegetables, and that the person would therefore have the gravy with the liver removed from it. They considered that this constituted a vegetarian meal as "it's not actually got meat in it." The definition set out above, supplied by the Vegetarian Society, indicates that the meal offered to the person on the day of the inspection was not vegetarian. We noted that this person regularly refused meals, and that the meals offered and refused were often not vegetarian, meaning it was possible that the person was going without food as the food offered did not meet their needs.

We raised this issue with members of the home's management team. They told us that they didn't think the person was "really vegetarian" and that they chose what they wanted. It was unclear therefore why the person's care plan contained information that the home's management team did not consider to be accurate.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We looked at the arrangements for storing and serving food safely. We noted that the cook had taken the temperatures of the food when it was first prepared that morning, but not when it was reheated for serving at lunch. They rectified this during the inspection and told us that they "always" did this. However, previous temperature records showed that only one temperature had been taken each day. The management team could not explain this and could not confirm that the day of the inspection was the first day that the cook had ever pre-cooked food for reheating at lunch. There was a record of fridge and freezer temperatures in the kitchen, however, there was no information about the temperature range that the fridge and freezer should remain within to ensure food was safely stored. The cook told us that they knew the safe range, but then could not tell us what it was.

We checked what information was available about food allergens that were present in the meals provided. The cook told us that the home's manager held this information, however, the manager told us that the cook kept these records. Neither the home's manager nor the cook were aware of the regulations which were imposed two years earlier which require all food providers to have information about which of 14 recognised allergens are in any food provided.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We saw that communication between staff and managers had improved since our last inspection, and noted that team meetings took place regularly. These were used to discuss developments within the service, the needs of people using the service and plans for changes and improvements.

Requires Improvement

Is the service caring?

Our findings

People told us they received good care at Victoria Lodge Residential Care Home. One person told us: "I love it here, very happy, well looked after and the food is lovely." Another said: "They are lovely here."

We observed staff talking with people and assisting them by carrying out care and support tasks. We noted that staff usually spoke with people with warmth and kindness, but there were occasions when staff failed to uphold people's dignity or privacy. For example, we saw one staff member came into the lounge where other people were sitting, and loudly tell another staff member that "[named person] wants to go to the toilet." There was no need for the staff member to do this so loudly and in front of other people. On another occasion we observed staff holding a conversation about what intimate care tasks needed to be carried out and for whom. Again this was done in front of other people and failed to uphold people's privacy. One staff member spoke to another in the lounge, saying: "If you are wondering why [a person] is in their wheelchair, it's because they won't get out of it, but they've been toileted." This was demeaning as again the conversation took place in front of others and did not afford the person under discussion any privacy or dignity

We looked at people's care records to assess to what extent they had been involved in developing their care and support plans. There was little evidence of involvement, and mostly it appeared that decisions about how a person should be cared for had been made by staff or people's relatives. There was a good level of personal detail within each care plan, indicating that the provider had taken time to assess people's individual needs and preferences, although we noted one of the files we looked at referred to another person's name in several of the care plans, suggesting it may have been "cut and pasted" from the other person's file.

The care plans we checked set out how people should receive care and support, and their daily notes and other records showed that on the whole staff were adhering to this although there were some exceptions. For example, one person's care plan stated that picture cards should be used by staff to enhance communication with them, but we did not observe staff doing this when they spoke with the person throughout the day of the inspection.

The home's manager told us that an external advocacy service was available, and some of the care plans we checked showed evidence that people had met with an advocate regularly.

The environment of the home was undergoing a programme to make it more dementia-friendly. Bedroom doors had been painted different colours to make it easier for people with cognitive impairment to orientate themselves, and brighter signage had been put in place. The home's manager told us that this programme was still ongoing, but we noted clear improvements since the July 2016 inspection.

Requires Improvement

Is the service responsive?

Our findings

There was a dedicated activities coordinator based at the home whose role involved designing and leading on an activities programme. Staff we spoke with told us there were plentiful activities available, although the activities programme appeared to be limited. Activities listed included "reading and article discussion," "films/musicals" and "one to one talks." During the inspection we observed staff to commence a game of dominoes with one person, however, the staff member left half way though the game and there was no other interaction with the person until staff cleared the dominoes away some time later. There was music from musical films playing in the lounge, but staff did not consult anyone about what music they might like to listen to.

We checked care records belonging to five people who were using the service at the time of the inspection. We found that people's care plans were reviewed regularly, with staff signing to say that they had reviewed the person's care over the previous month. However, where changes to the person's care plan might be needed these changes were not made. For example, the way one person should be supported had been changed by an external healthcare practioner, but their care plan had not been changed to reflect this. Another person had been noted to refuse several meals per week, but again there was no reference to this in their care plan.

There was information about how to make complaints available in the communal area of the home, and in the provider's Statement of Purpose, however, this directed complainants to an incorrect source of external remedy should their complaint through internal processes be exhausted. We saw that there had been no formal complaints received in the period preceding the inspection. We asked one of the people using the service whether they knew how to make complaints. They told us they would feel confident to complain. They said that they would complain to the manager and felt that they would be listened to.

Inadequate

Is the service well-led?

Our findings

When we inspected the home in July 2016, we judged the home to be inadequate for the domain of "well led." We found that audits were ineffective, and the home had not made required notifications to CQC. At the inspection of December 2016, we found ongoing concerns in this area.

The home's manager had been in post for six months at the time of the December 2016 inspection, however, they had failed to make an application to CQC to become registered manager despite it being a requirement of the home's registration that a registered manager is in post. We had discussed this with the provider and the home's manager in July 2016 and in August 2016, and on both occasions were assured that an application was imminent. We asked the home's manager why they had not taken the steps they assured us they would take. They told us this was because they had not understood how to acquire their Disclosure and Barring Service (DBS) check in order to make their application. CQC's website and helpline make this information readily available, and it was unclear why the home's manager had failed to gain the required information and submit their application in a timely manner.

We asked the home's manager to supply a copy of the home's most recent Statement of Purpose. The Statement of Purpose is an important document which all providers are legally required to have and keep under review. It sets out what services are available and who is providing those services. When a provider updates their Statement of Purpose they are required to notify CQC of any changes. The Statement of Purpose provided to us was updated in November 2016, although the provider had failed to notify CQC of this update. We found that it contained incorrect information, including stating that the home was registered with a regulator that ceased to exist several years earlier, and directing potential complainants to obsolete and incorrect avenues of external remedy. This meant that the provider had failed to ensure that the Statement of Purpose was accurate or fit for purpose, and the process of checking and reviewing it was inadequate.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Registration) Regulations 2009

We looked at the arrangements in place at the home for auditing the quality of service provided. The provider and home's manager had developed a detailed audit system which meant that checks were being carried out of many aspects of the home and the services provided. However, these audits had failed to identify where there were shortfalls, breaches of regulation or other concerns, indicating that the audit system was either unfit for purpose, or was not being implemented effectively. For example, there was a health and safety audit which was completed on a monthly basis. This audit had not identified any concerns since January 2016. However, during the inspection we noted that food was stored unsafely in an outbuilding. This issue had also been identified during the inspection of July 2016. As the audit had not identified this, nor had it made reference to the inspection report of the July 2016 audit, this meant that it was ineffective.

Another audit took place every month to look at whether complaints were being safely managed. However, the majorty we checked were incomplete as only a small number of questions had been answered. The

audit was designed to check whether people using the service and staff understood the complaints system, but this had not been considered for any of the months we checked.

A third audit checked the condition of the environment. We noted that for the November 2016 environment check a poor smell in the premises had been noted. There was no information recorded showing what action was required or whether it had been completed to address this concern.

The home's manager told us that people's care plans were audited every month, and this was confirmed by the deputy manager. However, we saw that in each of the five care plans we checked there were errors, omissions, contradictory information or a failure to comply with legal requirements. The audits had therefore been ineffective as they had failed to either identify or address this.

Since the inspection of July 2016, the provider and home's manager gave CQC assurances that they were taking steps to achieve and sustain improvements to the service. As part of this assurance they supplied action plans and self assessments to CQC with updates on their progress. We contrasted the latest update document with our findings of the December inspection. We concluded that the provider and home's manager were failing to recognise the home's poor performance. For example, the self assessment stated that the provider considered that required actions were completed in relation to providing evidence that the best interest requirements of the Mental Capacity Act were met. Additionally, it considered that the quality audits were effective. We found that neither of these areas had achieved the required standard, giving concern that the provider's governance systems were inadequate.

Further to the above self assessment, the provider submitted additional information to CQC setting out how it believed it had achieved compliance and addressed the breaches and shortfalls identified in previous inspections.This information was in the form of representations against action that CQC was proposing to take. However, again we found that the provider's description of their own position was inaccurate or gave cause for concern. For example, this document stated that consent documents were being signed by people's relatives, and that people's next of kin had the authority to "approve" care plans where people lacked capacity. This indicated that the provider was displaying an ongoing lack of understanding of the requirements of the Mental Capacity Act. The document also stated that care plans were being audited regularly which ensured that they met people's needs. We also found that this was not the case, meaning that the provider was failing to recognise what was required to address its own shortfalls.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014