Community Therapeutic Services Limited

Victoria Court

Inspection report

1 Victoria Park
Weston Super Mare
Somerset
BS23 2HZ

Tel: 01934629392
Website: www.cts-homes.co.uk

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

About the service
Victoria Court is a residential service providing personal care for up to 6 people with learning disabilities, mental health support needs and autistic people. The service consists of an adapted building, which includes individual bedrooms, communal spaces and an accessible outdoor space. At the time of our inspection there were 6 people using the service.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support:
People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. Staff supported people with their medicines in a way that promoted their independence. People had a choice about their living environment and were able to personalise their rooms. The service gave people care and support in a safe, clean, well equipped, well-furnished and well-maintained environment.

Right Care:
The service had plans and guidance for staff to support people with their individual risks. Staff understood how to protect people from poor care and abuse. Staff had training on how to recognise and report abuse and they knew how to apply it. The service had enough appropriately skilled staff to meet people's needs and keep them safe.

Right Culture:
The provider had systems in place to monitor the quality of the service to people. However, we found quality assurance systems were not being completed regularly to ensure quality and potential safety issues were identified and acted upon. People received support from staff who knew them well. The service enabled people and those important to them to work with staff to develop the service. Staff ensured risks of a closed culture were minimised so that people received support based on transparency, respect and inclusivity.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 23 July 2019) and there was a breach of regulation 17. At this inspection we found the provider remained in breach of this regulation. This service

has been rated requires improvement for the last two consecutive inspections.

At our last inspection we made recommendations regarding the management of medicines and mental capacity assessments. At this inspection we found the provider had acted on these recommendations and improvements had been made.

Why we inspected
We carried out an unannounced inspection of this service on 4 and 6 June 2019. A breach of legal requirements was found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions safe and well-led which contain those requirements.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

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

Enforcement
We have identified a repeated breach of Regulation 17 (Good Governance) at this inspection. Please see the action we have told the provider to take at the end of this report.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Victoria Court

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by 1 inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience contacted people's relatives by telephone to request their feedback.

Service and service type
Victoria Court is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Victoria Court is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection there was not a registered manager in post. There was an acting manager in place who had responsibility for the day to day running of the service. The acting manager was supported by registered managers from other services managed by the provider. Following the inspection, the provider informed us a registered manager had been appointed.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 4 people who used the service and 3 relatives. We spoke with 7 members of staff including the acting manager and other managers of services run by the provider. We undertook observations of people receiving care to help us understand their experiences. We reviewed a range of records. This included 3 people's care records and 3 people's medicines records. We looked at 3 staff files in relation to recruitment. A variety of records relating to the management of the service and quality assurance were reviewed including accident and incident records and management audits. We sought feedback from professionals who work with the service.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to good. This meant people were safe and protected from avoidable harm.

Using medicines safely

At our last inspection we recommended the provider reviews current guidance around the recording of medicines management. At this inspection we found improvements had been made.

- People received their medicines from staff who administered, recorded and stored their medicines safely. We found no errors or unexplained gaps in recording on medicine administration records (MAR).
- Guidance was in place for medicines prescribed 'as required' (PRN). However, we identified some examples where PRN guidance required more detail for staff to know how and when to administer each medicine. During the inspection the acting manager responded promptly and updated these records.
- Staff administering medicines had been trained to do so and their competency had been assessed.
- People told us they were satisfied with the support they received with medicines and could take their medicines in private when appropriate and safe. A person said, "Support is really good." Another person said, "Yes, I self-medicate. It's locked in my room."
- The service was completing a regular medicines audit to check people were receiving their medicines safely.

At our last inspection we recommended the service reviews published guidance around the review of capacity assessments and best interest decisions. At this inspection we found improvements had been made.

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

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

- People's rights to make their own decisions were protected.
- People told us staff sought their consent and respected their personal choices; our observations confirmed this. A person said, "They knock and ask are you happy for me to help you."
- Mental capacity assessments had been completed in relation to people's care and support needs and records showed decisions had been made in people's best interests where required.

● Where people were deprived of their liberty, appropriate referrals had been made to the local authority to ensure this was done lawfully and in the least restrictive way.
● Staff demonstrated an understanding of the MCA in line with the key principles.

Assessing risk, safety monitoring and management
● The provider had systems in place to assess risks to people before undertaking their care and support. Support plans contained risk assessments for areas such as people's behaviour, mobility and health conditions such as diabetes.
● The service was carrying out a range of building safety checks to ensure the safety of people living within the service, including electrical checks and fire safety.
● However, we found some health and safety and legionella checks were not up to date. We will report further on this in the well led section of this report.
● Where a person was being supported with their fluid intake the service had an appropriate support plan in place. The person's fluid intake was being monitored, however we found records were not sufficiently detailed. We raised this with the acting manager and during the inspection this was addressed.
● Risk assessments relating to people's behaviour were person centred and detailed with clear guidance for staff to support people in the least restrictive way. Where required, people's behaviours were monitored to identify any change in people's support needs.
● Health and social care professionals who worked with the service did not raise any concerns about safety. A professional said, "Communication with the home is very good, they respond to risks appropriately by alerting the relevant parties and always keep people updated."

Preventing and controlling infection
● The service was clean and well maintained. A person said, "The home is really clean, staff help with your room."
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
●The provider was supporting visits in line with the government's guidance.

Staffing and recruitment
● People and their relatives told us there were enough staff to meet their needs. Records and our observations confirmed this. A person said, "Yes enough staff." A relative said, "They seem to be well staffed."
● People told us they were supported by a regular team of staff who knew them well. A person said "I know all the staff here. I get on well with the staff."
● The service had safe recruitment processes. These included the completion of a Disclosure and Barring

Service (DBS) check, proof of identity and evidence of conduct in previous employment. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

● People were kept safe from avoidable harm because staff knew them well and understood how to protect them from abuse. The service worked well with other agencies to do so.

● People and their relatives told us they felt safe with the care and support they or their relative received. A person said, "Of course, 100 percent very safe." A relative told us, "Yes, [person] kept very safe."

● Staff had completed training and knew how to recognise and report any abuse and were confident any concerns would be acted upon.

Learning lessons when things go wrong

● Staff raised concerns and recorded incidents this helped keep people safe.

● A quarterly analysis was undertaken to review for patterns and trends and ensure actions taken to prevent reoccurrence were effective.

● The management team explained how following any incident they would notify the relevant authorities and share lessons learned with the team to help prevent any reoccurrence.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At our last inspection the provider had not ensured that governance systems were effective. At this inspection whilst some improvements had been made, governance systems were not being completed regularly to ensure quality and potential safety issues were identified and acted upon.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

- The service had systems in place to monitor the quality and safety of the service such as medication and accident and incident audits. However, governance systems were not fully effective in ensuring all areas had been checked regularly.
- The management team told us some service level audits and checks had not been regularly completed since the departure of the registered manager in December 2022, including health and safety and infection control audits.
- No concerns were identified in infection, prevention and control. However, the regular audits which were part of the services governance systems had not been completed.
- We found some people's risk assessments had not been reviewed, meaning the system to pick up on people's changing needs was not always effective, provider audits had also identified this. Whilst we found no omissions in people's risk assessment information, sufficient action had not been taken from the provider audits to address this.
- Provider audits had also identified the need for a service improvement plan, however sufficient action had not been taken to implement this.
- Medication audits were being completed; however, they did not identify and address the issue we found with medicines prescribed PRN.
- We found regular checks to manage the risk of legionella had not been kept up to date and where water temperature checks had identified some high temperatures within the service, there was no record of action taken in response. This meant we could not be assured these potential safety issues were being appropriately managed.
- The management team told us people had regular meetings with their allocated key worker, however records of these meetings were not being maintained. This meant the service could not assess the quality of support people received in these meetings.
- We were told a monthly managers audit which included checks on support plans, key worker meetings and health and safety checks was not being completed. Therefore, these issues were not identified and

addressed.

Whilst we found there was no evidence people had been harmed by the issues identified above, systems were either not in place or robust enough to demonstrate that there was adequate oversight of the service. This placed people at risk of harm to their safety and wellbeing. This was a repeat breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During the inspection, the acting manager took action to ensure water temperatures were safe and legionella checks had resumed.
●The management team told us they were addressing the shortfalls identified with management oversight within the service. Following the inspection, the provider confirmed a new registered manager had been appointed.
● There were systems in place to communicate with staff such as a daily handover meetings and staff meetings.
● We found some improvements had been made since the last inspection, relating to the management of medicines and mental capacity assessments.
● Whilst improvements were required, people and their relatives told us there was good communication with the service and it was well managed. They spoke positively of the acting manager and told us the service had improved under their leadership. A person said, "A lot better with [acting manager], I know he listens, he says I'll just finish this off and come and see me. He does it." Another person said, "Really well managed, staff listen to you, deal with people really well. Make sure you are good."
● The service sought the views of people and their relatives via satisfaction questionnaires.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The management team promoted a positive culture, which supported the delivery of person centred care and support. A person said, "Yeah, really good. Understanding, they listen, they help you, take you out, give you company." A relative said, "I've had input on the care plans over the years, the staff always include me in [person's] care planning."
● There was a positive and friendly atmosphere within the service. Staff knew people well.
● Staff told us they felt supported and could raise any concerns with the management team. A staff member said, "Yes, never been a problem, always receptive to any concerns."
● People and their relatives told us they were satisfied with the service. A relative said, "It's a lovely home, [person] gets on with the staff and [person's] very well looked after."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others
● Staff gave honest information and applied duty of candour where appropriate.
● The provider had policies in place which identified the actions staff should take in situations where the duty of candour would apply.
● The service worked with health and social care professionals to ensure people had the support they needed to maintain their health and wellbeing.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not always operate effective systems and processes to assess and monitor the quality and safety of the service