Key Healthcare

Victoria House

Inspection report

Victoria House
Park Road North
Middlesbrough
Cleveland
TS1 3LD
Tel: 01642 242 975
Website: www.keyhealthcare.co.uk

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Ratings

Overall rating for this service

Is the service safe?
Is the service effective?
Is the service caring?
Is the service responsive?
Is the service well-led?

Overall summary

We completed this inspection on 22 December 2014. This was an unannounced inspection which meant that the staff and provider did not know that we would be visiting. At this inspection we were following up the significant concerns identified during the inspection in November 2014.

At that inspection we found that there were breaches of 11 of the regulations relating to care from regulation 9 to 26, The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Also there were breaches of regulation 18 of the Care Quality Commission (Registration) Regulation 2009. We had serious concerns about the service provided in the Regent House unit and took immediate action to reduce the risk posed to people using this unit. The people who used the Regent House unit moved out on 6 December 2014.

Victoria House is registered to provide nursing and residential care for 68 people and the service operates across four distinct units. Up until September 2014 the home had three units; one for people with a physical disability; one residential unit for people living with a dementia; and a nursing unit for people living with a dementia. In September 2014 the provider started using a fourth unit, which they named Regent House. The provider described this service, as a specialist unit for the

Summary of findings

rehabilitation of people with enduring mental health needs which was staffed with registered mental health nurses 8am to 8pm seven days a week. This service is no longer provided as we imposed a condition to ensure this service was not operated at the home.

At the November 2014 inspection we found that there were breaches of virtually 13 of the regulations relating to care from regulation 9 to 26, The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Also there were breaches of regulation 18 of the Care Quality Commission (Registration) Regulation 2009.

We informed the provider of these concerns and received a comprehensive risk assessment identifying how these issues would be addressed on 8 December 2014. In the subsequent week the provider sent confirmation that action had been taken and provided a range of detailed information to support these assurances.

When we visited on 22 December 2014 we found that the work had been completed to ensure the service was meeting the remaining people's needs.

We found that the repairs had been completed. We were also provided with a refurbishment plan detailing how the general décor of the home would be improved and how they would ensure each unit would meet the specific needs of the client group using it. Also action had been taken to ensure the ambient temperature of the home did not compromise people's health. Staff were actively monitoring temperatures throughout the day and ensuring if they increased action was taken to ensure people remained hydrated.

At the previous inspection we found that the provider expected the registered manager to make the clinical decisions around whether people were admitted and to determine if they required residential or nursing care. The registered manager was not a nurse and did not have the appropriate clinical skills to make decisions about whether people needed nursing care for their needs or not. The provider took action to resolve this matter and a deputy registered manager who was a RMN came into post the week of our inspection.

The provider's statement of purpose and service user guide did not provide clear information for people who used the service around what the purpose of each unit. By 22 December 2014 these documents had been reviewed and contained clear admission criteria and were accurate.

We found that staff on the unit for people with a physical disability were being supported to consider goals associated with rehabilitation. An occupational therapist had reviewed the unit and following their recommendations the provider had purchased a range of adapted kitchen equipment, which we found were in situ. This meant people could be assisted to live more independent lifestyles.

We found that families had been invited to join the reviews and all of the people using the service had been seen by representatives from their placing authority.

Staff had some understanding of the requirements of the Mental Capacity Act 2005 but had not fully introduced either the principles or the appropriate documentation into the home. They had requested Deprivation of Liberty Safeguard (DoLS) authorisations for three people. Staff had not considered preventing other people from leaving units was a deprivation of liberty. The staff had not considered how these environmental restrictions of the unit could exacerbate their level of agitation and had not considered whether the person could safely access other areas in the home or the garden. On 22 December 2014 we found staff had received refresher training and were appropriately applying for DoLS and considering how to treat people in the least restrictive ways.

When we concluded our inspection the provider had resolved most of the breaches of regulations. Three remained, which you can see at the back of the full version of this report along with the enforcement action we took.

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?
We found that people who used the service and others were safe.

Staff met people's needs and ensured risks to people from the environment were reduced or minimised.

There were sufficient suitably qualified staff employed to meet people's needs. Recruitment procedures were in place and appropriate checks were undertaken before staff started work.

Medication was handled, stored and administered appropriately.

Is the service effective?
Staff had received support from the provider to ensure they had the skills, knowledge and experience to provide care to the various groups of people living at the home.

The requirements of the Mental Capacity Act 2005 and the Mental Health Act 1983 (amended 2007) were being met.

The catering staff did ensure people received a healthy balanced diet.

Is the service caring?
We found that the service was caring but improvements were needed.

Staff were very caring. They had the skills and knowledge needed to ensure they developed therapeutic relationships.

The service was not designed in a way that would promote people's independence and autonomy.

Is the service responsive?
People did received personalised care that was responsive to their needs. People were engaged in activities throughout the home.

The environment on the units for people who lived with dementia needed to be designed to support them to be as independent as possible.

When people raised concerns, staff recognised them as complaints or allegations of abuse and had pass to the registered manager to investigate.

Is the service well-led?
The provider had commenced monitoring and assessing the service. They had ensured that people who used the service were safe, received effective, caring and responsive services which met their needs.

Staff had been supported to ensure the way they worked empowered people to live as independent life as possible.

People who used the service and visitors views had been sought about the home.

Victoria House

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.

An adult social care inspector completed this unannounced inspection of Victoria House on 22 December 2014.

Before our inspection, we reviewed the information we held about the home and contacted the Clinical Commission Group (CCG) to obtain their views after their recent audit.

During the visit we spoke with three people who used the service, a relative, the operational manager, the deputy manager, one nurse, two care workers, and two staff from the training agency. We also undertook general observations of practices within the home and we also reviewed relevant records. These included five people's care records, four staff files, audits and other relevant information such as policies and procedures. We looked round the home and saw people's bedrooms, bathrooms and communal areas.

Is the service safe?

Our findings

At the November 2014 inspection

We identified significant concerns with a service the provider commenced operating in one of the home's units, namely Regent House.

We found that the provider's statement of purpose and service user guide was stated that registered mental health nurses (RMN) worked in the unit. We saw that nurse did not work on the unit. Seven people were residing on the unit and the placing authority's assessments for five people highlighted that six people required nursing care.

Staff who were working on the unit had limited understanding of what these risks meant for their practice or how to use the information in assessments. We found that the care staff had not been provided with any support to develop the skills needed to complete appropriate risk assessments around these types of behaviour.

In the Regent House unit we found that the people's care records contained no information to show that the staff at the home had completed any pre or post admission. For five of the seven people using this unit staff had not produced any care plans or risk assessments. We found that whilst the registered manager did notify the safeguarding team and us of some incidents, which had not been reported to the LA safeguarding team or us.

The high temperatures on the top floor were raised as concerns last year by us and air conditioners were installed. During the visit this time the temperatures remained excessive and at least 25°c throughout the two days. No action had been taken to routinely monitor the temperature on the top floor or to ensure action was taken when they became excessive. Although air con was provided these were portable units and during our visit staff never turned them on.

On the residential unit the dining room door was locked during the early hours and no jugs of water etc were available so no-one had access to drinks unless staff provided it. Throughout the visit the only drinks made available were at the discretion of the staff. Staff were not monitoring temperatures to make sure people were not at risk of dehydrating nor were they taking action to make sure people did not overheat or dehydrate.

Plaster had fallen off the ceiling in one communal area, which had not been repaired. A significant section of the ceiling above the false ceiling in coffee room had fallen down the week before our first visit. We found that no action had been taken to check that this had not compromised the integrity of the floor above or would lead to more of the ceiling falling down.

A designated smoking area was located in the yard, which people from the physical disability unit used frequently but no action had been taken to ensure the route to it was free from hazards and accessible. There was no lighting and to get there safely people have to be reliant on other people who used the service to give them a hand.

The residential unit for people living with a dementia was restricted to one small part of the top floor. People on this unit only had access to one lounge and a windowless area designated as the dining room. We saw and heard how the limited space exacerbated people's level of agitation and distress. This we found had led to them displaying aggression towards other people on the unit.

Other than the downstairs of the Regent House unit being painted the home had not been fully refurbished for a number of years. Paint was chipped, embossed wallpaper had clearly been repeatedly touched up and painted over for some considerable time and the carpets were shabby.

We made the provider aware of these issues following our visit on the 27 November and on 8 December 2014 we received an action plan identifying how these matters were to be addressed. The provider detailed to us their review of the Regent House unit and, as we had found, noted that the concerns raised related to the staff lacking the skills needed to looked after people with mental health needs not the building. On 12 December 2014 the provider asked us if they could use the unit for people living with dementia, which we agreed they could.

At the inspection on 22 December 2014

When found that all of the people at the Regent House unit had moved as had the person in the physical disabilities unit.

When found that the provider had commenced a full refurbishment of the top floor of the unit. This was so they could decommission the top floor residential unit and move it to the top floor of Regent House unit. Also we found that action had been taken to reduce the high

Is the service safe?

ambient temperatures of the unit and staff monitored temperatures throughout the day. We saw that people were supported to access sufficient fluids to ensure they remained hydrated and staff encouraged people to dress appropriately for the temperature of the unit.

We found that remedial decorative works had been completed to other areas of the home.

We found that the designated smoking area had been relocated to a safer part of the building. The provider had ensured a new smoking shelter had been constructed and appropriate lighting was in place. They had also risk assessed the access to this shelter.

We found that the provider had completed a comprehensive risk assessment of the home and taken action to repair the ceilings and other areas of the home. Also the provider had constructed a new smoking shelter, which was accessible; had lights; and was secure.

People and relatives we spoke with in the physical disability unit and dementia care services felt the service had improved over recent weeks. They were pleased with the improvements to the building and the plans for the top floor residential unit.

Is the service effective?

Our findings

At the November 2014 inspection

We found that there were insufficient suitably qualified staff working in the Regent House unit and no nursing cover provided on this unit. We found that staff on this unit had not received any training around the Mental Health Act and their role in overseeing requirements of Community Treatment Orders (CTOs), section 17 leave and guardianship orders that people who used the service were detained on. None of the staff working on the Regent House unit had received any other form of training in supporting people with mental health needs.

We found that although there was a high dependency nursing unit for people living with a dementia and a nursing unit for people with dementia, there was no information to outline the difference. There was no information to highlight the aims and the goals of the physical disability unit or clearly outline the criteria for admission to both this unit and Regent House unit. Therefore staff had no guidance to assist them determine if placements at the home would meet the person's needs or if the person could be cared for by staff at the home.

We found that the registered manager was unclear how they should be using the tool used to work out the staffing levels needed at the home. They struggled to outline to us exactly how many staff should be in each unit.

Staff had some understanding of the requirements of the Mental Capacity Act 2005 but had not fully introduced either the principles or the appropriate documentation into the home. They had requested Deprivation of Liberty Safeguard (DoLS) authorisations for three people but not considered what restrictions the other people who staff prevented from leaving units were experiencing.

The physical disability unit was designed for assisting people to live more independently and become able to live on their own. The provider had stated that the home could cater for people with physical disabilities but no assessment by qualified people such as OTs had been completed. Adapted cutlery, cooking equipment, dining furniture and chairs were needed but the provider had not supplied them.

People on the top floor units were segregated by a keypad door. This reduced the overall available space for people to use and made the residential unit very small. No explanation could be provided for this practice but it meant that on the residential unit the dining area was an enclosed box with no windows and only one lounge was available.

We made the provider aware of these issues following our visit on the 27 November and on 8 December 2014 we received an action plan identifying how these matters were to be addressed. The provider detailed to us their review of the Regent House unit and, as we had found, noted that the concerns raised related to the staff lacking the skills needed to looked after people with mental health needs not the building. On 12 December 2014 the provider asked us if they could use the unit for people living with dementia, which we agreed they could.

At the inspection on 22 December 2014

We found that many areas of the home were not Disability Discrimination Act compliant both in terms of meeting the needs of people with a physical disability and the needs of people living with a dementia. The dementia care units had not been developed to make the units dementia friendly so were not decorated in ways that enhanced people's level of independence and supported them to find their way around and to their own room. Recognised guidance had not been followed in respect of creating a dementia friendly environment such as how to use colour and material to make it easier for people to make their own way around a unit, find toilets and find meaningful occupation. The operational registered manager had started to review this and take action to ensure improvements were made to this unit.

This was a breach of Regulation 17 (2)(h) (Respecting and involving service users), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that the people on the top floor were no longer segregated. Action had been taken to decommission the residential unit on the top floor of the home and use the Regent House unit instead. We saw this would provide a much less restrictive environment and far more space for those people living with dementia.

A range of adapted kitchen equipment had been purchased and installed in the physical disability unit. Also the services in this provision had been reviewed by a

Is the service effective?

physical disabilities specialist and action had been taken to meet the recommendations. We saw that a wide range of adapted equipment was available throughout the three remaining units.

Refresher MCA training had been completed with senior staff and we found that staff had now completed appropriate capacity assessments plus looked at how to support people to make decisions. We saw that people were being supported to freely use the home and staffing had improved so that people could go out.

Is the service caring?

Our findings

At the November 2014 inspection

We reviewed 11 people's care records found that the contents were variable. The care records on Regent House unit did not detail people's needs, whether people were subject to any legal constraints such as sections of the Mental Health Act or how they were supported.

It was also unclear why some people resided on the unit for people with a physical disability, as this was not their need. For instance a person with no physical disabilities had been admitted to the unit because their relative preferred this environment. The people who used the service on this unit did not know what the aim of the service was or how they were to be supported. They were unclear whether they were being assisted to develop skills or just housed there.

We made the provider aware of these issues following our visit on the 27 November and on 8 December 2014 we received an action plan identifying how these matters were to be addressed.

At the inspection on 22 December 2014

We found we found that the statement of purpose and service user guide had been updated. Also clear admission criteria had been formulated and implemented.

We saw that staff treated people with dignity and respect. Staff were attentive, showed compassion, were patient and interacted well with people. We saw that when people became anxious staff intervened in very supportive ways and used techniques such as distraction and going to quieter areas of the home. The techniques the staff used effectively reassured people. We found staff sensitively and discreetly supported people to deal with their personal care.

Throughout our visit we observed staff and people who used the service were engaged in general conversation and friendly banter. From our discussions with people and observations we found that there was a very relaxed atmosphere and staff were caring.

Is the service responsive?

Our findings

At the November 2014 inspection

We found that only one of the five care sets of records reviewed in this unit contained any information written by staff at the home. Neither staff nor the registered manager could outline people's needs on this unit or what actions needed to be taken to support individuals or reduce any potential risks. For example, one person's placing authority's assessment stated they needed a very structured and secure environment to assist them reduce the risk of self-harm. Staff were unable to explain or demonstrate how they were able to provide this type of support.

We found that the assessment documents and care records for people using the physical disability unit only addressed their personal care needs and gave no detail about the goals they were working towards.

The provider expected the registered manager to make the clinical decisions around whether people were admitted and to determine if they required residential or nursing care. The registered manager was not a nurse and did not have the appropriate clinical skills to make these decisions.

One person on the Regent House unit with physical disabilities highlighted that the only toilet and shower did not have the adapted equipment they required. We found that no action had been taken to obtain an assessment of their needs then adapt the service accordingly.

We saw that this concern had not been recognised as a formal complaint and therefore no action had been taken to investigate the failing in the system. We heard from relatives and people who used the service that they had made formal complaints. These were not recorded in the home's complaint file so it was unclear what actions had been taken. The registered manager told us she was unaware of these complaints.

We witnessed people raising concerns about the provision in the Regent House unit and physical disability unit but saw that staff did not treat these as complaints; support people to raise them formally; or discuss them with the registered manager.

We made the provider aware of these issues following our visit on the 27 November and on 8 December 2014 we received an action plan identifying how these matters were to be addressed.

At the inspection on 22 December 2014

We found that the admission criteria had been reviewed and updated to ensure staff had clear guidance. Also a deputy registered manager had been appointed who was a registered mental health nurse. We found that this person was very experienced and could readily outline differences between what would be considered nursing and residential care.

We found that group supervision had been conducted with staff, which had detailed the importance of ensuring people were supported to raise concerns and outlined the complaints procedure. Also the operational manager had taken action to ensure all complaints were thoroughly investigated and accurate records were made.

Is the service well-led?

Our findings

At the November 2014 inspection

We found that the provider had commenced operating Regent House unit without ensuring staff were equipped to meet the needs of the individuals admitted. Neither had they ensured the registered manager had the skills necessary to ensure only people the unit could support were admitted.

The registered manager told us that they were unaware of the systems the provider had previously operated for overseeing the home. So they had developed some systems for monitoring and assessing the effectiveness of the home. But they were in the early days of creating these and many were not in place. They did produce a training matrix that highlighted many gaps but told us they had yet to develop action plans to detail how to address the issues. We found that the system for monitoring the performance of the home could not be confirmed as effective.

Employees of the provider's bank completed the required provider review called a regulation 10 visit and report. No evidence was available to show that the provider used this report or the home's information to ensure the service operated effectively and risks were managed.

The home has a physical intervention policy but this stated that staff were not to use physical interventions. We found that across the home staff needed to either physically intervene, use sedative medication or mechanical restraints in the form of locking doors. Staff did not understand that their actions would be considered as physical interventions. Due to this policy no physical intervention training was provided and staff did not have access to appropriate recording templates so none of the care records were appropriately completed. No information was provided to show if staff needed to lay on hands how this was to be done.

As shown throughout this report we identified that there were significant deficits in the performance of the home and skills of the staff. The provider did not have systems in place to ensure these were identified by their staff.

We made the provider aware of these issues following our visit on the 27 November and on 8 December 2014 we received an action plan identifying how these matters were to be addressed.

At the inspection on 22 December 2014

We found that the provider had instructed the operational registered manager to undertake all future regulation 10 visits. The operational manager in the weeks between 8 December and 22 December 2014 had completed a comprehensive review of the service. They had developed actions plans to address all of the issues we highlighted plus ones the critical review had noted. We found that appropriate action had been taken to deal with the issues and most were resolved.

The operational manager had updated the physical intervention policy so it was accurate and supported staff to take appropriate action. Invoices were produced to show staff were booked onto courses that would teach them breakaway techniques, which are interventions staff can use to deal with physical aggression in the least restrictive manner.

The provider had provided additional managerial support in the form of a deputy manager who was a qualified and experienced RMN and another registered manager from one of their other homes. They had also employed additional heads of care for the physical disability unit and the residential dementia care unit. These staff members were equipped with the skills to make decisions about whether staff could meet the needs of people who were referred to the home.

The registered manager and operational manager had also re-instated the routine quality assurances processes the provider had in place.

We saw that regular audits had been carried out on the environment, hoists, bedrails and equipment to ensure that it was safe. Any accidents and incidents were now being monitored and the organisation to ensure any trends were identified.

Albeit improvements had been made to the systems for monitoring and assessing the service it was too early to determine if these would be effective long-term. Also records had been improved but further work was needed.

This remained a breach of Regulations 10 (Assessing and monitoring the quality of the service provision) and 20 (1) (Records), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **People who use services and others were not protected against the risks of inappropriate or unsafe care because an effective system for monitoring the service was not in place.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **The nursing unit for people living with a dementia has not been designed to ensure people were supported to remain independent.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **The provider failed to ensure accurate records were maintained in respect of each person using the service and the management of the home.**