Four Seasons Health Care (England) Limited

Victoria Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on 21 and 26 April 2016.

Victoria Care Home is located in the village of Rainford, St Helens, providing nursing care and support for up to 53 residents. The service which is part of the Four Seasons Health Care group, is a modern, purpose built facility, with 46 single bedrooms, and six double bedrooms, set over two floors. The ground floor, Alexander unit accommodates people who require nursing care. The Edward unit on the upper floor, accommodates people requiring care and support with dementia and related conditions. At the time of this inspection 51 people were living at the service.
A registered manager was in post. 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.

At the last inspections in July and December 2013 we found that the service was meeting all of the regulations that we assessed.

We have made a recommendation that the registered provider considers best practice for use of people's chairs is considered under the Mental Capacity Act 2005 to ensure that individual's best interests are considered at all times. Where appropriate people assessed and not having the mental capacity to make specific decisions had supported under the Mental Capacity Act 2005. Staff had received training in the Mental Capacity Act 2005 and demonstrated an awareness of the basis principles of the Act.

We have made a recommendation that registered provider reviews their procedures in relation to reporting significant events to ensure that the appropriate regulations are met. Not all of the notification required had been sent to the Care Quality Commission.

Procedures were in place to protect people from abuse and people told us that they felt safe living at the service. All staff had received training in safeguarding vulnerable people.

People's medicines were stored appropriately and systems were in place to ensure that people received these when they needed them.

Sufficient staff were on duty to meet the needs of people. Effective recruitment procedures were in place to minimise the risk of people not suitable to work with vulnerable people being employed.

Risks to people's health, safety and wellbeing were assessed and plans had been put in place help ensure that they received the care and support they required.

People's dietary needs were planned for and when required, monitored to ensure that people had sufficient

amounts to eat and drink.

People were supported by a staff team who received regular supervision, training and support for their role. This meant that the staff team had up to date knowledge of current best practice.

A complaints procedure was in place and people were confident that any concerns they raised would be listened to.

The registered provider had several systems in place to gather people's views on the service they received. This helped ensure that people were able to comment on the standards of care and support they required on a regular basis.

Regular audits took place around the service to ensure that the environment was safe and people's care planning documents and medicines were kept up to date.

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.

Sufficient staff were employed to meet people's needs.

Safeguarding procedures were in place to protect people from harm.

People's medicines were managed safely. This helped ensure that people received their medicines when they needed them.

Staff were safely recruited, which helped ensure that only staff suitable for the role were employed.

Is the service effective?

Good

The service was effective.

Systems were in place to ensure that people dietary needs were monitored which ensured that people received sufficient food and drink.

People received care and support from staff who had received appropriate training for their role.

The registered provider had systems in place to assess people's ability to make their own decisions under the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People felt that they were supported by staff who were kind and caring.

People's privacy and dignity were respected by the staff supporting them.

Systems were in place to help ensure that people received the care and support they required as they approached their end of life.

Is the service responsive?

Good

The service was responsive.

People's care needs were planned for and reviewed on a regular basis, which meant that up-to-date information was available to staff.

People knew how to raise a complaint about the care they received and felt that their concerns would be listened to.

Is the service well-led?

Requires Improvement

The service was required improvement to be well-led.

Significant incidents and information had not always been reported to the Care Quality Commission.

People knew the registered manager and felt that she was approachable.

People, their relatives and staff had the opportunity to comment on the service delivered at any time.

Systems were in place to monitor the quality of the service and make improvements when required.

Victoria 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 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 21 and 26 April 2016 and was unannounced.

The inspection team consisted of two adult social care inspectors.

We looked in detail at the care planning records of six people who used the service. In addition, we looked at records in relation to the management of the service, the recruitment records of four recently recruited staff, policies and procedures and staff rotas. We spoke with 10 people who used the service and spent time with a further eight people in communal areas. We spoke with four staff, the registered manager and the registered providers area manager.

Before our inspection we reviewed the information we held about the service including incidents that the registered provider had sent to us since our last inspection. We contacted the local authority who commissioned the service to obtain their views. They told us that they had no concerns about the service provided to people at Victoria Care Home.

Good

Is the service safe?

Our findings

People told us that they felt safe living at the service. Their comments included "I am safe here, they look after me well" and "It's a good clean, safe place here".

Visiting relatives told us that they felt the service was a safe place for their relatives to live.

Policies and procedures were in place in relation to safeguarding people from abuse. Staff were able to describe the different types of abuse that could occur, and the signs and indicators to look for if they suspected a person was at risk. Staff were clear that any concerns would be reported to the registered manager immediately. Records demonstrated that all staff had received awareness training in safeguarding vulnerable people. The registered manager demonstrated a clear understanding of the local authority's safeguarding procedures and what action needed to be taken in the event of suspected or actual abuse being reported.

Systems were in place to ensure that people received their medicines in a safe and timely manner. We observed medicines being administered on two occasions during our inspection. Staff administering medicines were seen to give people sufficient time to take their medicines comfortably.

Medicines administered were recorded on medication administration records (MAR). These records contained the details of all treatment prescribed for people. MARs contained details of any allergies that people may have and details about the medicines prescribed. Medicines prescribed on an 'as and when' basis had also been appropriately recorded. This helped to ensure that appropriate records were maintained around when a person had been offered or administered medicines prescribed for them.

All medicines were stored securely in line with the registered provider's medicines policy and procedures. The temperature of the fridges in use to store medicines were monitored daily. In addition, the temperature of the rooms in which medicines were stored were also being monitored. We found that the records of these temperatures demonstrated that the rooms were becoming warmer, which meant that there was a risk that people's medicines may lose their efficacy. For example, on the day of the inspection the temperature of the upstairs medicines room was 23c. We discussed the appropriate temperatures for the room with staff who demonstrated that they would take action to ensure that medicines were stored within the manufacturer's recommended temperatures.

Sufficient staff were on duty to meet the needs of people. Rotas demonstrated the number of staff on duty for that day. The registered manager used an electronic planning tool that considered the needs of people and helped calculate the number of staff required to be on duty. People told us that sufficient staff were on duty most of the time and that they did not have to wait long if they needed assistance. Throughout our visit we observed the use of the call bells used by people to request attention from staff. We saw that when a person used the call bells, these calls were answered quickly. This meant that people did not have to wait for a long period of time to get the assistance they needed.

People were protected as recruitment procedures were in place that ensured that only staff suitable to work with vulnerable people were employed. We looked at the recruitment records of the four most recently employed staff members. The information demonstrated that appropriate recruitment procedures had taken place. For example, we saw that a completed application form, written references, photographic proof of identity and a record of interview questions and responses had been completed. In addition, we saw that Disclosure and Barring Service (DBS) checks had been completed. A DBS checks enables employers to check the background of potential staff to ascertain if they have previously been barred from working with vulnerable people.

Risk assessments were in place to ensure that identified risks to people were minimised. For example, we saw that risk assessments had been developed in relation to people's nutrition, skin integrity and risk of falls. The risk assessments gave clear information to staff as what actions were needed to support people. Assessments were reviewed on a regular basis and changes made when needed. This helped ensure that identified risks to individuals' were managed appropriately.

Accidents and incidents were recorded electronically. The registered manager demonstrated the system in place to record and report accidents and incidents to the registered provider. This system enabled the registered manager and provider to monitor any incidents and where identified, make improvements to minimise risks to people. For example, in the event of a person experiencing a number of falls a review of or introduction of a risk assessment would take place.

Regular checks were carried out around the service to help ensure people's safety. For example, we saw that regular checks were carried out in relation to health and safety and fire detection systems. A handy person was employed to carry out these checks and to carry out regular maintenance around the service.

The service was clean and tidy. People told us that their bedrooms were cleaned on a regular basis. Personal protective equipment was available throughout the service to prevent cross infection. For example, gloves and aprons were seen to be used by staff when delivering personal care and paper towels and soap dispensers were available around the building.

Good

Is the service effective?

Our findings

People told us that they had regular access to health care professionals. One person told us "You just need to ask and they [staff] will call the doctor".

People had differing opinions about the meals available at the service. Their comments included "The food is very good" and "The food is ok, not great". All of the people spoken with told us that there was always plenty to eat and drink.

A visiting relative told us positive things about the care their relative received. Their comments included "They were loosing weight before they came to live here but is now maintaining her weight. The staff know the people here".

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 make 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 checked whether the service was working within the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met, and found that they were. DoLS were in place for the people who needed them. At the time of this inspection 28 people had a DoLS authorisation in place. People's records contained information that demonstrated that an assessment of people's decision making had been considered and assessed. For example, one person's care planning documents contained clear information relating to the support they required in relation to the MCA for the use of bedrails and other complex decisions. Guidance was available to staff as to what constituted simple decisions the person was able to make independently, for example, choice of food and clothes.

The registered provider had purchased number of specialist chairs for a number of people. The purpose of these chairs was to promote comfortable seating for individual. We saw that that a number of people were unable physically get out of their chair independently nor were they able to request support to get out of their chair.

We recommend that the service considers best practice for use of these chairs in relation to the MCA to ensure that people's best interests are considered at all times.

Training records demonstrated that all staff had received training in the MCA . The registered manager and staff all demonstrated a good understanding of the MCA. Staff told us "Mental capacity, its when people have the ability to make decisions and retain information. Its decision specific. You also get fluctuating capacity" and "We make sure that everyone gets the opportunity to make basic decisions. We give them

[people who use the service] choice, but also have to act in their best interests at times".

Systems were in place to enable people's dietary needs and preferences to be planned for. For example, risk assessment tools were used to measure if a person was at risk from a lack of hydration or nutrition and people's hydration and nutritional needs were monitored on a regular basis. In addition people's weight was regularly monitored. When a person had been identified as at risk, a system for monitoring people's nutritional intake was available. This involved keeping regular records of what people had eaten and drank, which were reviewed on a regular basis.

When a particular need had been identified the registered manager demonstrated that appropriate specialist advice and support would be sought. For example, following a person experiencing a choking episode the registered provider's internal training team carried out observations, liaised with kitchen staff and developed a report / action plan to minimise the risk of the person choking again.

People had the choice of eating their meals in their bedrooms or the dining rooms. We saw people being offered a choice of hot and cold drinks throughout their meals. Within the downstairs dining room we saw that people were sat chatting around the dining tables with the mealtime appearing a social occasion. We sat with people having their lunch in the upstairs dining room and we saw that improvements could be made to people's mealtime experience. For example, one person was experiencing some confusion and was struggling to eat their meal. Four staff were seen to ask the person if they were ok and started to assist but then left. A member of staff was seen to give verbal encouragement of "Try this, try this, try this" from the opposite side of the dining table. After some time we asked a member of staff to sit with the person to assist them to have their meal comfortably. We spoke with the registered manager regarding our observations in the upstairs dining rooms who stated that they would address the issue immediately.

Records demonstrated and staff confirmed that they received regular supervision for their role. The registered manager confirmed that she provided clinical supervision for registered nurses. This helped ensure that people received care and treatment from staff that were supported in their role.

People were supported by a staff team that received regular training for their role. Records demonstrated that staff had received training which included basic life support, medicines management, health and safety, equality and diversity, safeguarding adults and child protection. Registered nurses employed at the service had also completed training which included basic life support, malnutrition in the elderly, venepuncture, catheter and syringe driver training. People told us that they felt staff were equipped with the knowledge to meet their needs.

Good

Is the service caring?

Our findings

People told us that staff were respectful when delivering care and support. People's comments included "Staff are very caring, they respect me" and "The care staff are nice, They are lovely in fact". All of the people spoken with told us that staff would do things differently if they asked them to.

One person told us that staff were respectful of their wishes. They told us that they "Enjoy the company of others but I also like to use the quiet lounge and staff respect this".

A visiting relative told us positive things about the care their relative received. Their comments included "Staff are good and helpful, [relative] gets upset but they [staff] handle things really well". They told us that they visited every day and they felt like they were "Part of a big family".

People were happy and comfortable with the support they required. Staff were seen to be caring in their approach to people. For example, we saw staff addressing people in a gentle manner whilst being close to them and maintaining eye contact. There was lots of laughter and friendly banter and it was evident that staff knew people well and that positive relationships had been formed between people and the staff that supported them.

We saw that staff maintained people's dignity whilst supporting them in communal lounges. For example, we saw staff using a hoist to transfer a person and this was done discreetly. Staff were able to demonstrate how they ensured that they maintained people's privacy. For example, one member of staff told us that they "Knock before entering, supervise people if they can do things themselves, just don't do it for them", "Close curtains and let people choose, for example what to wear" and "if people seem a bit embarrassed, help them, talk to them, explain to them what you are doing". One member of staff told us "I treat people like my mother and father. I give them choice, they're people , some with difficulties, but they deserve respect".

People's bedrooms were furnished with their own personal effects. Two people told us that they had brought a number of personal effects from their previous address which had made their bedrooms feel like theirs. A number of bedrooms had been fitted with window blinds. One person told us that the blind gave them the privacy they wanted.

People who were being cared for in bed had access to their personal effects. Bed tables were in place which contained things important to them, for example TV control, drinks, call bell, handbag and tissues. All of these things were in easy reach of people so they could access them comfortably.

Where people had wished, their care plans contained information about their end of life plans. For example, we saw that people had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) which gave instruction about decisions around resuscitation. In addition we saw that another person had made an advanced decision around their end of life care. This decision demonstrated what the person wished to happen as they approach their end of life. This information is important as it ensures that people's end of life wishes are known so that appropriate arrangements can be put in place.

The registered provider was in the process of introducing a pilot of a new care initiative titled the 'Demenia Care Framework' which was due to start on the 25 April 2016. The framework was to be introduced over an 18 week period with the intention of improving the experiences of people living with dementia. Planned work around the first floor of the service included improvements to the environment, training for staff on the experiences of people using the service, the use of music to support people and integrating people's rights into their everyday care experience. The aim of the project was to ensure that people living with dementia received a person centred approach whilst living at the service.

A 'relatives' room was available for visiting relatives to have access to an area that they could have refreshments and a place to sit quietly. The registered manager told us that people's relatives had found this room useful when they had been visiting their relatives who were unwell or who were approaching end of life.

A number of thank you cards were available from people who had previously used the service and their relatives. People had written positive comments about the care people had received. These comments included, "Thank you for the loving care, compassion and friendship you've given to our mum over the past five years", "I would like to thank you for all the care and affection you gave to my mum. She was very comfortable and happy during her stay" and "Thank you so much for looking after my mum during the last few weeks. Everyone was so professional but, more importantly everyone was kind, compassionate caring and thoughtful".

Good

Is the service responsive?

Our findings

People told us they were happy with the service they received. Their comments included "They [staff] look after us well" and "I'm happy, and the staff do everything I ask. Very comfortable thank you".

Prior to a person moving into the service an assessment of their needs took place. The purpose of this assessment was to ensure that the service had the facilities to meet the person's individual needs. In addition, the information gained during the assessment helped to develop the person's individual care plan.

Each person had their own flle which contained their personal information and care planning documents. We looked at the care planning documents of six people and saw that they contained information as to what support they needed throughout the day and night. For example, people's care plans considered needs relating to mobility, continence, personal care, decision making, pressure areas and medical needs.

People's needs were clearly recorded in their care plans. For example, one section of the care plan stated 'what is a good day' for the individual. This information informed staff that a good day for the person was when there was no twitching or shaking in their body. A bad day was defined as when the person was shaking a lot and that it was important to them to spend time alone at these times. Having this information available helped ensure that staff were able to provide the appropriate care and support to the person depending on what type of day they were having. It also gave insight into the experiences of the person and helped staff understand these experiences.

Care plans detailed information regarding what care and support a person needed in the event of them refusing care and treatment. For example, one person's care plan stated that if they were to refuse their medicines staff were required to return at a later time to offer the medicines again. This demonstrated a skilled approach to ensuring people received the care and support they needed.

Supplementary records for monitoring people's health and wellbeing formed part of people's care plans. For example, regular monitoring was in place and recorded in relation to people's skin when a person had been identified as being at risk. This monitoring helped ensure that in the event of a person's needs changing appropriate care and support was delivered in a timely manner.

Care planning documents demonstrated that people had access to community health care professionals. For example, audiology clinic and anti-coagulant clinic. Having access to the support of community health care teams helps ensure that people's clinical needs are planned for.

An acitivites co-ordinator had been in post for approximately eight weeks to offer stimulating activities to individuals and groups of people. They were in the process of developing activities to meet the needs of people. For example, there were plans to introduce arm chair exercises, organising a summer fair and accessing talking books for people. A silver letter service had been set up in conjunction with a local school

which gave the opportunity for people to write and receive letters from the children at the school. During our visit we saw people playing bingo, having afternoon tea and doing crafts. People had mixed opinions of the activities available. One person told us that they didn't think there was sufficient activities, another person told us they enjoyed the activities and another told us "I know there are things to do but I prefer not to get involved, I know I can if I want to".

The registered provider had a comprehensive complaints procedure in place and information as to how access these procedures was available around the building. A clear system for recording and responding to complaints was in place. This process included recording all information electronically which was then monitored by the registered provider. People told us that they knew who to speak to if they were unhappy and wanted to make a complaint about the service they received. They told us that they would tell the registered manager and they were confident that any concerns would be addressed appropriately.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager who had been registered with the Care Quality Commission for several months. Prior to taking up the post of registered manager they had worked at the service for several years. The registered manager knew the people who used the service well and was able to summarise in detail individuals' needs and wishes. People who used the service told us that they knew who the registered manager was.

There was a clear line of accountability within the staff team. Staff were aware of who their line manager was and who they could gain advice and support from at any time. Staff had access to a 24 hour on-call manager during weekend and out of hours. This helped ensure that advice could be sought if a situation arose within the service which required management support. Staff spoke positively about the service. Their comments included "Staff are able to give feedback on the ipad" and "It's a good functioning care home, I am happy here. We do the best we can to make people's lives good".

By law services are required to notify the Care Quality Commission of significant events. For example, when a Deprivation of Liberty Safeguard has been authorised for a person, when a person dies and accidents and incidents occur. Not all of the reportable incidents that had occurred at the service had been reported to the Care Quality Commission by the registered provider. For example, we had not been informed of Deprivation of Liberty Safeguard authorisations, one safeguarding concern and of a person requiring treatment following a fall. During a discussion, the registered manager recognised that not all of the significant events that had occurred had been reported appropriately.

We recommend that the service provider reviews their procedures in relation to reporting significant events to ensure that the appropriate regulations are met.

Audits of accidents and incidents were completed on a monthly basis which also included medicines errors and falls experienced by people. Records demonstrated that this system was effective in identifying changes to people's needs. For example, one person had experienced two falls in one month which had triggered a referal to the community falls team for advice and support.

The registered provider had several ways to gather people's views and experiences of the service they received. There was a computerised feedback point at the entrance of the building where people could leave their feedback. The service operated a 'resident of the day' system in which each person's care plans, risk assessments and views on the service were reviewed and updated where necessary. This system ensured that people's care and support needs were reviewed and updated on a regular basis. In addition, the registered manager walked around the service on a daily basis speaking with people. The outcome of these conversations was again electronically recorded and the results analysed by the registered provider. An action plan was devised following any areas of improvement identified by people. Relatives, staff and visitors also had access to the computerised feedback point

In addition to the registered manager's daily walk around of the service weekly and monthly audits also took

place. These audits included the environment, infection control, Deprivation of Liberty Safeguarding in place, health and safety and people's medicines. The outcomes of these audits were reviewed by the registered provider and when an improvement was identified, for example a training need for staff was identified action was taken.

A representative of the registered provider visited the service on a regular basis to review the service and offer support to the registered manager. This demonstrated further that the service people received was being monitored by the registered provider.