Victoria Lodge Care Home Limited

Victoria Lodge

Inspection report

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23 May 2018

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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

The inspection took place on 18 and 23 May 2018 and was unannounced.

Victoria Lodge is a residential care home registered to provide accommodation and care for up to 23 people, the majority of whom have a diagnosis of dementia and/or other care needs. At the time of our inspection, 21 people were living at the home. Communal areas include a sitting room, dining room/conservatory and access to a rear garden. Accommodation is over three floors and is serviced by a lift. Victoria Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and care provided and both were looked at during this inspection.

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.

Following the last inspection, the service was rated as 'Good' overall, with 'Requires Improvement' under 'Effective'. At the last inspection in May 2016, we asked the provider to take action to make improvements in relation to staff training, supervision and appraisal. Improvements had been made in these three areas and the service remains rated 'good' overall.

Notifications that the provider was required to send to us by law had not been done in relation to Deprivation of Liberty Safeguards authorisations. Records such as Medication Administration Records (MAR) had not always been completed accurately. Information relating to prescribed medicines on MARs had been hand-written by a member of staff, but had not been checked by another member of staff in line with the service's quality assurance process or National Institute for Clinical Excellence guidelines. The services quality assurance processes had not picked these omissions up and therefore is an area that requires improvement.

Some information was provided in an accessible format and the registered manager informed us this was work in progress. Activities were organised for people.

Staffing levels were consistent, Staff commented on how busy it could be at certain times of the day.

Staff knew how to keep people safe and had completed training in safeguarding adults at risk. A range of risk assessments had been completed in relation to people and premises. New staff were recruited safely. The home was clean and tidy and staff had completed training in infection control.

Staff completed a range of mandatory training and were encouraged to study for vocational qualifications. Menus for people were planned in line with their dietary needs, likes and dislikes. Drinks were freely

available. People received support from a variety of healthcare professionals. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice.

People were looked after by kind and caring staff who knew them well. As much as they were able, people were involved in day-to-day decisions and choices. Staff were reassuring and friendly with people and treated them with dignity and respect.

Care plans were detailed and written in a person-centred way. Activities were organised for people and there were plans to employ an activities co-ordinator. Complaints were managed in line with the provider's policy.

Staff were involved in the development of the service and their feedback obtained through staff meetings. Employee satisfaction surveys had been completed by staff to gain their views about working at the home. Compliments from relatives were received and recorded. Residents' meetings took place and people were asked for their views and suggestions about the home. The registered manager had involved the services of a consultant to advise them on how an outstanding rating could be achieved.

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

Staffing levels were consistent.

Management of medicines was safe

Staff had completed training in safeguarding and understood how to keep people safe.

Recruitment systems were robust.

The home was clean and tidy.

Is the service effective?

Good

The service was effective.

Improvements had been made with regard to staff completing a range of training.

The premises was being made 'dementia-friendly'.

People enjoyed the food on offer and had access to a range of healthcare professionals and services.

Staff had completed training in mental capacity and put what they had learned into practice. People's consent was gained lawfully.

Is the service caring?

Good

The service was caring.

People were looked after by kind and caring staff who knew them well. They were treated with dignity and respect.

People were encouraged to make decisions relating to day-to-day choices and their care.

Is the service responsive?

Good

The service was responsive.

People and/or their relatives were involved in reviewing the care plans.

Activities were organised and planned for people living in the service.

Information was provided for people in an accessible format.

Care plans provided information and guidance to staff about people's care and support needs.

Complaints were recorded and outcomes documented.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

The provider had failed to notify the Commission of Deprivation of Liberty Safeguards authorisations and of a diarrhoea and vomiting outbreak in 2017, which they were required to do.

Quality assurance systems had not always been effective in identifying issues.

The provider was aware of their responsibilities in relation to Duty of Candour and a whistleblowing policy was in place.

Staff meetings were held and employee satisfaction surveys were completed.

Residents' meetings were held so people's views could be obtained. A number of compliments had been received from relatives, thanking staff for the care their loved ones had received at the home.

Victoria Lodge

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 was an unannounced, comprehensive inspection which took place on 18 and 23 May 2018. The inspection team consisted of an 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. Their area of expertise was in dementia.

Prior to the inspection we reviewed the information we held about the home. This included information from other agencies and statutory notifications sent to us by the registered manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection. A request for the provider to complete a Provider Information Return had not been sent by the Commission, therefore, the provider was unable to complete this. A Provider Information Return is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection we spoke with eight people who lived at the home, one relative, the registered manager, deputy manager, cook, two care staff and the laundry assistant. We spent time observing the care and support that people received and also observed a member of staff administering medicines to people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records about people's care and how the home was managed. These included five care records and medicines records. We also looked at staff training, support and employment records, audits, minutes of meetings, menus, policies and procedures, complaints and other records relating to the management of the home.

Good

Is the service safe?

Our findings

At the last inspection in May 2016, we rated this key question as 'Good'. At this inspection, we found this key question remained 'Good'.

On the first day of our inspection, a radiator situated at the end of the dining room was extremely hot to the touch and there was no radiator cover in place to prevent people coming into direct contact with the radiator. This put people at risk of being burned. A stock of medicines that had recently been delivered had been left in a lobby area at the front of the home. The door to this area had been bolted, but did not provide secure storage as anyone in that part of the home could have gained access by sliding the bolt. A staff member told us that when medicines were delivered they would be put in the front lobby until staff had time to check them in. In addition, a medicines trolley had not been secured to a solid wall when not in use.

On the second day of our inspection we saw the provider had taken immediate action to rectify these. The registered manager informed us that they would ensure that stocks of medicines were kept securely and were reviewing the arrangements. The thermostat had been adjusted to ensure the radiator in the dining room did not overheat and a radiator cover been affixed. The medicines trolley had been moved to another part of the dining room and was fixed securely to a wall.

At the time of our inspection, 21 people were living at the home, the majority of whom had a diagnosis of dementia. People had different support needs, for example, seven people required two staff to assist them when mobilising. Staffing rotas showed that on weekdays, the deputy manager and three care staff were on duty in the morning, with two care staff in the afternoon and at night. At weekends, a senior member of the care staff was on duty, with three staff in the morning and two during the afternoon. In addition, the registered manager worked on weekdays and was on call at weekends. Ancillary staff such as housekeeping, catering and maintenance staff were also on duty during the week. The provider showed evidence of how they determine staff numbers after the inspection. We found no evidence to show that staffing levels were unsafe or that people were put at risk because of the staffing level

Agency staff were not used. We asked staff if they felt there were sufficient staff on duty to meet people's needs and received a mixed response from staff. One staff member said, "It's all right, It's busy. I don't think it's understood by the manager how busy it is. It takes time to get people up and there's no time for activities in the morning". This staff member said it, "could be a struggle, between 8am and 9am", with three care staff available to provide personal care as the deputy manager or senior would be administering medicines at that time. Staff were also expected to support people with activities on occasion. A second staff member said it was busy in the mornings and stated, "You can't rush people. In the afternoon, there's more time for activities.

Staff had completed training in safeguarding adults at risk and knew what action to take if they had any concerns. One staff member said, "My role is to safeguard, protect and care for people's individual needs". A copy of the local authority's policy in relation to safeguarding was available for staff to refer to in the

dining room. A relative told us, "My wife is very settled here and I feel she is safe and comfortable". One person said, "The staff are always around".

We looked at a range of risk assessments within people's care records. People's risks relating to falls, nutrition, challenging behaviour and skin integrity had been assessed and information provided to staff on how to manage people's risks. Personal Emergency Evacuation Plans had been completed, should people need to be evacuated from the home in the event of an emergency. Risks in relation to the premises, such as fire safety, had been addressed appropriately. Records showed that checks had been made in relation to gas safety, emergency lighting, fire alarm testing, electrical safety and lifts were completed. Equipment, such as hoists, was regularly checked and serviced.

A robust system was in place in the recruitment of new staff to ensure their employment histories were checked, references obtained and their suitability to work in a care setting was vetted through checks with the Disclosure and Barring Service (DBS).

We looked at the management of medicines and the Medication Administration Records (MAR). At least three MARs, which recorded the medicines people had been prescribed, had been hand-written by a member of staff. Ideally MARs will be printed off by the prescribing GP or pharmacy, but there will be occasions when this will be not be possible. In these circumstances, it may be necessary for a trained member of staff at the home to hand-write a MAR. However, the MARs we looked at which had been handwritten had not been witnessed by another member of staff for accuracy. The National Institute for Clinical Excellence under 'Managing medicines in care homes' states, '1.14.9 Care home providers should ensure that a new, hand-written medicines administration record is produced only in exceptional circumstances and is created by a member of care home staff with the training and skills for managing medicines and designated responsibility for medicines in the care home. The new record should be checked for accuracy and signed by a second trained and skilled member of staff before it is first used'. The provider evidenced that they had taken action to rectify this immediately.

We observed a member of staff administering medicines to people at lunchtime and this was done safely. Where people were being given medicines covertly, that is without their knowledge, a best interests decision had been taken and was recorded as needed, in line with legislative guidelines. Monthly medicines audits were completed and an annual audit had been undertaken by the prescribing pharmacy.

The home was clean and tidy. We spoke with a member of staff about how they managed the laundry and they had a good understanding about soiled laundry and how this should be washed. Staff had completed training in infection control.

Good

Is the service effective?

Our findings

At the last inspection in May 2016, we rated this key question as 'Good'. At this inspection, we found this key question remained 'Good'.

At the inspection in May 2016, we found the provider was in breach of a Regulation associated with staffing. We asked the provider to take action because staff did not receive appropriate support, training, supervision and appraisal necessary to enable them to carry out the duties they were employed to perform. Following the inspection, the registered manager sent us an action plan which showed what steps would be taken to meet this regulation. At this inspection we found improvements had been made and staff had received training and support.

According to the provider's supervision policy and procedure, 'Every employee will be invited to a supervision session with their manager or supervisor at least 6 times each year, and more often if a performance problem is under discussion. Supervision sessions will take place in private'. Staff records we looked at showed that staff had not received regular supervisions in line with this policy. For example, one staff member received a supervision in January 2018, but none since. Another staff member had received supervision and appraisal in July 2017, but no other meetings had been recorded. A third member of staff had received supervision in January 2018 and a further brief supervision meeting was recorded for May 2018, with an appraisal in February 2018. No other meetings were recorded. One member of staff told us their last supervision was, "At the end of last year and I've just had my annual appraisal".

Where supervision meetings had taken place, records showed the discussion that had taken place and identified any areas for improvement or actions needed. However, records of subsequent meetings did not always show how any outstanding actions had been addressed in the period between supervision meetings.

At the last inspection in May 2016, we found concerns in relation to the training that staff received with regard to mental capacity and other topics in relation to their job roles. Improvements had been made and a staff training plan showed that staff had completed a range of training. Some training was delivered face to face, for example, moving and handling and first aid. Other training was completed by staff electronically. Staff were up to date in their training in relation to areas such as diet and nutrition, infection control, dementia awareness, health and safety and falls safety awareness. Staff were encouraged to study for additional qualifications such as vocational, work-based training and National Vocational Qualifications (NVQ) in health and social care.

We observed people having their lunch and the majority chose to sit in the dining room. Where required staff were available to assist people with their meals and joined them for lunch. There was a lot of banter around the lunchtime meal between people and staff. People were sat at tables and engaged in conversation with each other making the meal a sociable occasion. One person told us, "The food is lovely". The menu for the day had been written-up on a blackboard in the dining room. Staff asked people what they would like to eat as the lunchtime meal was served.

We spoke with the cook who had a good understanding of people's dietary needs, including their likes and dislikes. Menus were planned over a four weekly cycle and changed in summer and winter. Menus were discussed at residents' meetings and the cook told us of a recent meeting where it was decided to try something different, for example, kippers at breakfast. Food was home cooked using fresh ingredients. In between meal times, people had access to snacks such as crisps, biscuits and fresh fruit. Drinks were freely available and we saw staff encouraging people to drink and offering them drinks of their choice.

Where people required input from district nurses, visits were arranged and we met with one district nurse who was visiting at the time of our inspection. The registered manager told us that one of the dementia matrons had delivered training to staff at the home. Staff from community services worked with the home to support home staff to deliver effective care and support to people. Care records showed that people had access to healthcare professionals and services as needed, such as diabetic nurses, GPs and opticians.

The majority of people living at Victoria Lodge had a diagnosis of dementia. The registered managed told us how they were continuing to work to make the service more 'dementia-friendly'. For example, improve signage and using photo's and pictures as prompts for people.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. The 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).

People's consent was gained lawfully. Staff had completed training on MCA and DoLS and had a good understanding of the legislation and codes of practice. One staff member said, "People have choice to make decisions, but we can intervene if people are at risk". Everyone living at the home was subject to DoLS, five of which had been authorised by the local authority, with the balance in progress. Capacity assessments had been completed for people and best interests decisions taken and documented as needed.

Good

Is the service caring?

Our findings

At the last inspection in May 2016, we rated this key question as 'Good'. At this inspection, we found this key question remained 'Good'.

People were looked after by kind and caring staff who knew them well. One person thought their relative had stolen everything and said, "Staff look after me here. They told me not to worry and took me out to buy some clothes". A relative told us, "I can come in whenever I want to see my wife. Staff always greet me and make me a cup of tea". We observed many occasions of staff interacting with people and that these were positive, reassuring and friendly. Staff exhibited a compassionate way of supporting people and told us they enjoyed working at the home. One staff member said, "The care staff here are fantastic. Mornings are very busy and staff spend personal time with people. It's important to spend time with people. This is people's home and I love working here". Another staff member told us, I can chat to the residents and take tea around. Everyone is so friendly". A third staff member, when asked what they thought was the best thing about working at Victoria Lodge, told us, "Being able to look after the residents. I worry about them when I'm not here. It's making people happy and comfortable".

As much as they were able, people were involved in making decisions about their care. We saw staff consulting with people on a range of everyday choices, such as what they wanted to eat and what they would like to do. We completed an observation of staff interacting with people during the lunchtime meal. Staff supported people in a discreet way that made them feel comfortable. For example, one person decided to use the tablecloth to wipe their mouth and a staff member gently intervened and suggested they might like to use their serviette. The deputy manager who was administering medicines sat next to people and waited patiently while they took their medicines, offering reassurance to people throughout.

People were treated with dignity and respect and they were given the privacy they needed. We saw staff knock on people's bedroom doors before entering. We asked staff about the importance of treating people with dignity and respect. One staff member explained, "I always tell people what I'm going to do and I give them choices. I cover people up when I'm giving personal care. I like to have a little joke with them as well, it's their home".

Good

Is the service responsive?

Our findings

At the last inspection in May 2016, we rated this key question as 'Good'. At this inspection, we found this key question remained 'Good'.

People received care that was responsive to their needs. Care plans were detailed and provided information and guidance to staff about people's care and support needs, including their personal histories, likes and dislikes. Care plans included information in relation to people's personal care needs, health needs and medicines for example. Staff discussed people's care and support needs at handover meetings held between shifts. The registered manager told us they were looking into changing from hard copies to having records in an electronic format.

From August 2016 all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively. The registered manager told us that providing information in an accessible format was work in progress. The inspector suggested at mealtimes pictures or photos would enable people to choose what they wanted to eat in an accessible way.

Within care plans, a page entitled 'My care summary' provided information about people that was easy to read. People's diverse needs were catered for. For example, one person was partially blind, and they had access to talking books. Discussions had taken place at residents' meetings regarding the use of MP3 players and tablets for people to access music and films on an individual basis. Some people had mobile phones which they used to keep in contact with people of importance to them. A laptop was available to people for communal use and some people had been supported to set up Facebook pages to keep their relatives updated on what had been happening to them and at the home. The registered manager told us they had tried to invite members of the clergy into the home to look after people's religious or spiritual needs, but had not been successful in this.

People living with dementia are at greater risk of becoming socially isolated. We asked people if activities were organised and what they thought about these. There were items available to people to interact with, for example, scarves, teddies, dolls and magazines, but people were not showing an interest in them. Staff had more time to spend with people during the afternoon than in the morning. Activities had been organised for people, for example, an entertainer came to sing to people on the second day of our inspection and plans were being made to celebrate the Royal Wedding of Prince Harry. We saw people were involved in making 'wedding cakes' and the dining room was decorated with bunting and flowers. Some people had recently enjoyed a tea organised by the Body Shop which they had enjoyed. One staff member told us that people enjoyed bingo and quizzes and that outings had to be planned. They added, "If people stay in their rooms, there's no real 1:1 time with activities". The registered manager told us they had plans to recruit an activities co-ordinator for four days a week to plan group and 1:1 activities with people inside the home and for community outings. A 'wishing tree' was on display in the lounge area where people could make a wish about something they would like to do. Staff would then try to make their wish come true. For

example, one person wanted to visit a garden centre, which had happened.

We looked at the complaints policy and at the complaints received during the year to date. Each complaint had been recorded with the outcome of actions taken. The majority of complaints were in relation to repairs or maintenance of people's rooms and each was rectified as needed.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in May 2016, we rated this key question as 'Good'. At this inspection, we rated this key question 'Requires Improvement'.

Notifications that the provider was required to send to us by law had not always been completed promptly and sent to the Commission as needed. For example, notifications in relation to Deprivation of Liberty Safeguards authorisations were not sent to us until 20 May 2018, after we reminded the registered manager of their statutory duty to do this. The registered manager told us that they had been unable to send these notifications through to us before because the 'provider portal', the tool used to send through the notifications, had not been working properly. However, one authorisation had been granted by the local authority in February 2018 and another in March 2018, but these had not been notified to us until 20 May 2018. The Commission operates a variety of ways in which providers can send notifications, such as via email or through the post, should the provider portal not be operating correctly. In addition, we learned that a diarrhoea and vomiting (D and V) outbreak occurred during 2017. Whilst the provider reported this event to Public Health England as required, they did not notify the Commission, which they should have done, since this was an event that prevented the normal running of the service.

Medication Administration Records (MAR) had not always been completed and witnessed in line with good practice. Analysis of accidents and incidents had not always been picked up through the provider's auditing systems. This meant that service's quality assurance processes had not always been effective.

The above evidence demonstrates that the provider had failed to notify the Commission of information they should and that their quality assurance was not always effective. This is an area for improvement and any new system needs to be embedded into practice.

We were given a copy of the provider's Statement of Purpose which states the care objectives of the home. It includes aims of upholding human and citizenship rights of all who work, live and visit the home and that individual choices and decisions are the right of all service users. The registered manager was passionate about the home and keen to make improvements to deliver high quality care. They told us, "You can never learn enough. I just want to keep improving". We discussed Duty of Candour and the registered manager explained this as, "Being open and honest from the start and reporting things". A whistleblowing policy was in place. The registered manager was part-owner of the home and had registered to become the manager in August 2017. They told us there had been some resistance from staff with regard to changes in the culture of the home and in the delivery of person-centred care. Staff were encouraged to participate in the development of the home and a staff meeting held in January included a discussion of the vision and values. An employee satisfaction survey was sent to staff in June 2017. Out of the 23 surveys sent out, 11 staff had responded, with satisfactory results. Staff meetings were held and we looked at the records of staff meetings held in January, April and May 2018. One staff member told us that staff meetings were regular and that they were aware of two meetings held this year. They added, "It's improving more and more now because of the things we're doing. This is home from home, they're like my relatives. I like working here. We've had lots of changes, but I'm quite happy with the way things are run. [Named registered manager] is

here and it is like a team. The manager has been on the floor lately". The registered manager said, "It's about creating a team and making the staff feel valued. There's a lot of team building I need to work on".

We looked at the compliments that had been received which had been sent by relatives. One relative had written, 'Thank you for all you did to make my Mum's last years joyful and happy'. Another relative had written to the inspector, 'I cannot speak highly enough of the care my mother has received since she moved in. She is treated with kindness, dignity and respect at all times by all the staff'. A third relative stated, 'Thanks for caring for Mum and on a personal note, I also want to thank you all for the unfailing kindness extended to me during my visits to her'. The registered manager told us they planned to organise an information session for families on dementia and mental health on 19 June. Family satisfaction surveys were sent out in January 2018. Out of 21 surveys sent out, nine families responded. Overall the responses were positive, with the lowest score in relation to activities, which one relative described as 'average'.

Residents' meetings were organised and we looked at the minutes relating to March and April 2018. People were asked for their views on their care, the food, laundry, technology, activities and what they liked about the home.

The registered manager had involved the services of a consultant to advise them how an outstanding rating could be attained; this was what the registered manager was striving to achieve. We looked at information collated in a 'Continuous Improvement' folder. This noted the actions taken against the consultant's recommendations and improvements that were planned, together with actions taken.