Accord Housing Association Limited

Victoria Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Victoria Court is a nursing home providing nursing care to nine people at the time of the inspection. The service can support up to 16 people. Victoria Court accommodates people across three separate wings, each of which has separate adapted facilities including a kitchen and living area.

People's experience of using this service and what we found
Whilst people reported feeling safe and cared for in the home, there was not a consistent approach to assessing people's risks and taking action to reduce these.

People were not always protected from risks relating to the environment where they were at risk of self-harm.

People received their medicines safely from trained staff, however, medicines audits had not always identified where the service had not disposed of medicines where people had left the service.

Quality assurance tools had failed to identify where improvements were required in people's care and documentation.

We have made a recommendation about people socially isolating in line with government guidance when newly admitted to the home.

Staff were knowledgeable about safeguarding and people felt able to raise concerns.

The home was clean and staff understood their infection control responsibilities.

People told us that staff were responsive to their needs and we received consistently positive feedback about staff and the management team.

People were encouraged to be involved in their care planning and making decisions around their care.

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

Rating at last inspection
The last rating for this service was requires improvement (published 19 April 2019). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made or sustained and the provider was still in breach of regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected

This was a planned inspection based on the previous rating.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to people's safety and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.

Details are in our safe findings below.

Victoria Court

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was completed by one inspector.

Service and service type
Victoria Court 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 the care provided, and both were looked at during this inspection.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because the service is small and people are often out and we wanted to be sure there would be people at home to speak with us.

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

During the inspection
We spoke with five people who used the service about their experience of the care provided. We spoke with four members of staff including the registered manager, deputy manager and care workers. We reviewed a range of records. This included three people's care records and multiple medication records. We looked at a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We also spoke with one professional who had regular contact with the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found there had not been sufficient improvement and the service remained in breach of regulation.

● At our last inspection we found risk assessments did not comprehensively assess risk and provide staff with sufficient detail to mitigate risks. At this inspection we found whilst people had risk assessments in place, these did not always accurately reflect how at risk people were. For example, one person was at risk of eating uncooked foods and required support with meal preparation, however their risk assessment had rated them as independent with this task. Records confirmed this person had not been supported on numerous occasions with meal preparation and this placed the person at increased risk.
● Risk assessments did not consistently contain clear guidance for staff to follow. For example, one person was at risk of self-harm and their risk assessment did not contain guidance on how staff could reduce this risk. This placed the person at increased risk of the health implications associated with self-harming behaviours.
● People were not always supported to reduce their risks of being in the community. For example, where people were at risk of sexual exploitation the management team had not taken a proactive and consistent approach to assessing risks around their safety whilst in the community and given staff clear guidance on how to mitigate these risks.
● The management team had failed to implement an effective way to monitor when people were leaving the service to access the community. This placed people and staff at risk in the event of an emergency.

Learning lessons when things go wrong
● Lessons were not always learned when things went wrong. For example, records showed following an incident relating to a person going missing from the service on multiple occasions, the registered manager had failed to take action to reduce the risk of further occurrences. This placed the person at continued increased risk.

Systems were either not in place or robust enough to demonstrate people's safety and risk were effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● People received their medicines as prescribed by trained staff. One person told us, "I get my medicines on time. Staff let me have a lie in sometimes and just shout me to grab them, they prompt me if I forget."
● Despite this, we observed there was no effective system in place to ensure medicines were always disposed of in a timely way following a person leaving the service. For example, we found a medicine in the fridge which was prescribed for a person who had left the service one month before we inspected. We raised this with the registered manager who acted immediately to adapt their daily medicines audit to check all medicines stored were prescribed for people still living at the home.

Preventing and controlling infection
● People were not always encouraged to isolate in line with government guidance when newly admitted to the service. This placed people at increased risk of exposure to COVID-19. We recommend the provider consider and implement current guidance on people being admitted to care homes.
● Staff wore appropriate PPE and washed their hands regularly. There were hand sanitisers on the walls around the service for people to access as they wished.
● The service was clean and well maintained. Staff were aware of government guidance relating to increased cleaning of high touch areas around the service and were cleaning all touch points hourly.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe. One person told us, "I feel safe here. It's a wonderful community."
● Staff knew how to recognise the signs of potential abuse and how to report and record their concerns. Records confirmed staff reported concerns to the local safeguarding team as they were required to.

Staffing and recruitment
● People told us there were sufficient staff to meet people's needs in a timely and flexible way. One person told us, "There are always enough staff here and there is always staff around if I need something."
● Staff had been recruited safely in line with the provider's policies.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
At our last inspection the provider had failed to ensure people's care plans were person centred. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found enough improvement had been made and the service was no longer in breach of regulation.

● Due to the concerns raised around people's risks not always being managed we could not be assured people's needs were consistently met. Despite this, people were encouraged to make choices around their care provision and staff had built good relationships with people to understand their preferences.
● People's care plans included person-centred information about their likes and dislikes and future wishes. One person told us, "[Staff and I] did my care plan together and I am very happy with it."

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● People were supported to communicate in a way they felt comfortable doing so. For example, the service supported a person to make decisions around their care who had had limited English by offering a translator.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● People could access a variety of independent and group activities within the home as they wished. For example, there was a foosball and snooker table in the communal lounges.
● People were encouraged by staff to try new things. For example, staff had supported a person to do some baking. The person told us, "I was baking cakes with [a staff member] and I jokingly said I should end up with a certificate and [staff] made me one." This had improved the person's wellbeing.

Improving care quality in response to complaints or concerns
● The provider had a complaints policy in place and people knew how to complain and felt comfortable to do so. One person told us, "If I was worried about something, I could speak to staff about it."

End of life care and support

● There was no one at the service currently receiving support with end of life care, however people had made their wishes known within their care plans. For example, we saw one person had written in their care plan the music they would like to be played at their funeral.

Requires Improvement

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements, Continuous learning and improving care
At our last inspection the provider had failed to ensure quality assurance tools had identified where improvements were required at the service and change was implemented effectively. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found there had not been sufficient improvements and the service remained in breach of regulation.

- Systems were not in place to effectively monitor and assess the quality of the service. For example, concerns raised at the inspection had not been identified through the registered manager's quality monitoring of the service in relation to medicines.
- Quality assurance tools had failed to identify where risks related to self-harm, exploitation and nutritional needs had not been effectively assessed and clear guidance put in place for staff to follow to mitigate these risks. This placed people at increased risk of harm through inconsistent staff action based on their judgement as opposed to guidance provided by the registered manager.
- Systems in place to monitor who was present in the service at any time were not effective as they were not consistently used by people at the service. This placed people at increased risk should there be an emergency such as a fire.
- The provider had failed to drive and sustain improvements and to ensure compliance with the regulations. At this inspection we found sufficient improvement had not been made and the service remained in breach of regulations in relation to keeping people safe and oversight at the service.

Systems were either not in place or robust enough to identify and sustain improvements to the quality of care and documentation at the service. This placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had displayed their previous rating clearly on entrance to the service and on their website.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
- People and staff gave consistently positive feedback about the registered manager and management

team. One person told us, "[The management team] make you feel you are being acknowledged and accepted." Another person told us, "I like the manager they are one of us. Totally down to earth. They inspire me to work hard, knuckle down and to regroup. They have taught me to not be afraid of who I am and not to be ashamed."

● The management team worked with us during the inspection to address areas of immediate concern we raised in relation to risk management and quality monitoring.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager understood their responsibilities under the duty of candour and was meeting these.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The registered manager sought feedback from people through regular key worker sessions and service meetings. However, all people told us they would not wait for these to occur should they have feedback as they felt both the registered manager and staff were very approachable.

Working in partnership with others

● The registered manager worked closely with external organisations such as drug recovery agencies to enable people to seek support should they wish to with drug dependencies. One professional told us the service had been, 'absolutely incredible' in supporting people during COVID-19.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The inspection identified continued concerns around the governance and oversight at the service. Quality assurance tools had failed to identify concerns we found during the inspection and to drive and sustain improvement.