Heritage Care Homes Limited

Victoriana Care Home

Inspection report

6 Lansdowne Road
Luton
Bedfordshire
LU3 1EE

Tel: 01582484177

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Victoriana is a residential care home providing personal care to 21 people at the time of the inspection. The service can support up to 34 people.

People's experience of using this service and what we found
The home was clean but there were infection control risks due to the upkeep and maintenance of the home by the provider. Staff wore the correct personal protective equipment (PPE) and there were social distancing measures in place at Victoriana. However, we identified some short falls in how cross contamination and COVID-19 risk was managed. The registered manager spoke with the professionals to address these issues. We also found there were insufficient plans in relation to the management of a COVID-19 outbreak and the winter pressures in general.

People received their medicines, but there were some shortfalls too in staff practices in this area of people's care. In relation to staff not being distracted when administering people their medicines and accurately recording if a medicine was declined or not.

The provider's quality monitoring processes needed improving in order to identify shortfalls and areas of improvement and take effective action to resolve them.

People and their relatives told us they were happy living at Victoriana. Relatives spoke well of the staff and managers.

We found staff were thoughtful and caring towards people. Staff knew the people they supported and understood people's mental health needs. They were sympathetic to the difficulties of living with dementia. People were involved in their care and were asked about their views of how their key needs were met by the managers and staff.

Staff had a good understanding about what their role was if they identified any potential harm or abuse. There were risk assessments and plans were in place to guide staff and the managers to respond to the risks which people faced, but sometimes these needed expanding further.

There were improvements made following the last inspection, we could see the managers had worked hard to make these improvements and to respond to COVID-19.

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

Rating at last inspection (and update)
The last rating for this service was Inadequate (the report was published on 15 November 2019). There were multiple breaches of the regulations. The provider completed an action plan after the last inspection to

show what they would do and by when to improve. At this inspection we found improvements had been made, but there were still two continued breaches of the regulations.

This service has been in Special Measures since 15 November 2019. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

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

The inspection was prompted in part due to concerns received about how COVID-19 and the risk of COVID-19 was being managed at the home. As a result, we undertook a focused inspection to review the key questions of safe, caring and well led only.

The overall rating for the service has changed from inadequate to requires improvement. This is based on the findings at this inspection. We found evidence that the provider needs to make further improvements. Please see the safe, caring and well led sections of this full report. The provider has taken some action to respond to these issues. You can see what action we have asked the provider to take at the end of this full report.

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

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 caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Victoriana Care Home

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by one inspector and an assistant inspector.

Service and service type
The Victoriana 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We announced this inspection twenty minutes before we entered the home. This was to clarify the COVID-19 measures in place and to identify if any person(s) were isolating.

What we did before the inspection
We spoke with our colleagues at the local authority to gain their views of the service. We reviewed our records about the service. We also 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 this information to plan our inspection.

During the inspection
We completed many observations between people and staff and general staff practice. We completed a thorough check of the service in relation to hygiene and infection control. A medicine check was completed for three people. We also spoke with two people who lived at Victoriana and the deputy and registered manager.

After the inspection
We reviewed records in relation to people's risk assessments and plans, the safety of the building and equipment used, and staff recruitment checks. We looked at plans the management had for managing an outbreak and the winter pressures. We telephoned five members of staff and seven people's relatives to obtain their views of 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 inadequate. At this inspection this key question has now improved to requires improvement. 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.

Preventing and controlling infection; Assessing risk, safety monitoring and management

At our last inspection the provider had failed to ensure there were effective risk assessments and plans in place to promote people's safety. Staff knowledge about protecting people from harm was limited, and there were infection control issues, which put people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Improvements had been made in this area, but not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- The home was clean, but there were some malodours. The entrance area had a smell of stale water. One toilet had a strong smell of urine which permeated into the hallway near a person's bedroom. Another toilet was regularly used by people. This meant it needed closer monitoring by staff, but this had not been identified.
- Despite the home being clean there were some infection control risks due to the upkeep and maintenance of the home. Some furniture was damaged, flooring had deteriorated in parts of the home, areas around toilets and skirting boards needed attention. Some toilets were stained.
- There were gaps in the registered managers processes to prevent cross contamination and manage COVID-19. These gaps were in donning and doffing personal protective equipment (PPE), how used PPE was disposed of and where staff washed their hands. We have signposted the provider to resources to develop their approach.
- Further monitoring was needed in relation to a person who smoked and who had COVID-19, when they went outside and engaged with other people who smoked. The smoking hut made for this person was not fire retardant. People who were isolating who had COVID-19 did not have updated evacuation plans.
- People had risk assessments in place but sometimes these needed more consideration to fully explore and plan the risks identified.
- There were gaps in the plans and processes to manage an outbreak of COVID-19 and the winter pressures. Those most at risk of becoming unwell if they get COVID-19 did not have assessments and plans to respond to this risk.
- We saw a fire exit was blocked by a chair outside where some staff smoked. No evacuation drills had happened in two years.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was 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.

● Staff were seen to wear PPE correctly and systems were in place to promote social distancing.
● The home had a recent virtual fire assessment from the fire service and passed. Fire drills took place.

Using medicines safely
● We were not satisfied medicines were always being managed safely. We looked at a sample of three people's medicines. Some medicines were not accounted for. One medicine staff had signed they had given it and it was declined. Another could have been an error when the medicine arrived. But this had not been identified.
● A member of staff was observed for 20 minutes giving medicines. They wore a tabard alerting staff not to interrupt them. In this time, they spoke with two staff and a member of staff spoke to them about people's care needs. This could cause a medicine error.
● People's prescribed creams did not always have an open date on them. Which meant they could be used, after the period had expired, when they were not safe to use.

Systems and processes to safeguard people from the risk of abuse
● People were protected from abuse. All the staff we spoke with had a clear understanding of what potential abuse could look like, and what they should do about it.
● Systems were in place for the registered manager to process concerns.

Staffing and recruitment
● Staff employment checks took place to ensure staff were suitable. Staff had references verified and DBS (Disclosure and Baring Service) checks completed. But there were some gaps in staff's employment histories which were not clarified at interview.

Learning lessons when things go wrong
● The management team and provider were open to suggestions and guidance, but they did not always seek this support themselves. We found this with how COVID-19 was being managed in the home.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to good. This meant people were supported and treated with dignity and respect and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

At our last inspection the provider had failed to ensure people's dignity was always promoted at the home. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 10.

● The people we could speak with spoke positively of the staff and managers. One person said, "Those girls can't do enough for me, they're all lovely." A person's relative said, "I think everyone is treated really well in the home, I have been updated throughout COVID-19, contacted me about the flu jab, contacted about visiting and kept me well informed." A further person's relative said, "The staff treat them [people] brilliantly. I would go and ask [name of person] how she is, I would say would you rather be in our own house, [person] says they do look after me here."
● Staff talked to us about people's emotional and physical needs. They were able to show us they had formed or were trying to form relationships with the people they supported. Staff showed an understanding for people who had mental health needs and who lived with dementia.

Respecting and promoting people's privacy, dignity and independence
● We observed staff were polite, thoughtful, and respectful to the people they supported. Staff knocked on people's doors before they entered them. Staff assisted people in discreet ways when they needed support.
● The managers worked with one person to support them to move into more independent living.
● Before the lockdown in November 2020 people were supported to go out into the local area, the park, shops, and to see relatives.

Supporting people to express their views and be involved in making decisions about their care
● People completed questionnaires and surveys on the care they received. We saw people approached the managers and the managers helped people when they needed support with wider aspects of their care such as finances.

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 inadequate. At this inspection this key question has now improved to requires improvement. This meant the service management and leadership was inconsistent. Leaders did not always support the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Working in partnership with others

At our last inspection the provider had failed to ensure there were effective auditing systems to ensure high quality care was always provided. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some improvements had been made in this area, but not enough improvements had been made at this inspection and the provider was still in breach of regulation 17.

- We found gaps in how cross infection and COVID-19 was being managed in the home by the management team and provider. The provider had not identified these gaps when they audited and checked the service.
- We identified shortfalls in how donning and doffing of PPE was carried out by staff and how PPE was disposed of. We identified potential cross contamination risks. The managers and provider were not checking how staff took their PPE off and on.
- There were insufficient plans and systems to prepare the service for an outbreak and the winter pressures. The management did not know how much PPE stock they actually had nor did they have a system to check this. Initiatives to prevent and manage an outbreak were just being considered, despite the fact the pandemic had started in March 2020 and there was an outbreak at the home.
- During the inspection we identified areas which might benefit from outside professional advice, such as systems in place for disposing of used PPE and staff taking PPE off. The outside resources available to the service had not been utilised.
- The environment was in parts, in a poor state of repair, which posed a potential infection control risk.

We found no evidence that people had been harmed however, the leadership was not effective at times in promoting safety and monitoring the quality of care provided. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- We observed an improved culture of the staff team at this inspection. Staff responded to people in a thoughtful and friendly way. People engaged with staff in ways which showed us they had made a

connection with them.
● People were supported to share their views of key aspects of their care.

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; Continuous learning and improving care
● People's relatives told us they had open conversations with the managers when things could be improved upon for their relatives and they had positive outcomes.
● There was a willingness to learn from others and from mistakes made, the service had improved since the last inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk of experiencing harm as there were shortfalls in how to prevent cross contamination in the home. Processes for managing Covid19 did not always reflect government guidelines. There were some potential infection control risks. Regulation 12 (1) (a) (b) (d) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of effective systems to ensure quality safe care was always provided. Regulation 17 (1) and (2) (a) (b) (e)