Mrs Reepaben Patel

Victoria House Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Victoria House is a residential care home providing personal and nursing care to up to 20 people. The service provides support to older people, people living with dementia and people with physical disabilities. At the time of our inspection there were 11 people using the service.

People's experience of using this service and what we found
People's medicines were not always managed safely. There were a number of issues including; the lack of protocols in place for people who received as required medicines and a lack of running totals of some controlled drugs, these are medicines which require specialist storage by law. Storage of some medicines were not in line with legislation.

Risks to people's safety was not always clearly recorded. There was conflicting information in people's records about their care needs as changes to their needs occurred. There was a lack of processes to show clear learning from events.

Quality assurance processes were not always robust. This had resulted in some of the findings above. Some audit findings had not been addressed, such as areas of concern highlighted in environmental audits.

More positively, staff were knowledgeable about people's needs. There was enough staff to support people as the registered manager and their staff team worked extra shifts to ensure people were well supported.

Staff recruitment processes were safe.

People and relatives liked the staff who supported them and felt they were caring and approachable. During our inspection we observed a number of positive interactions between staff, the people they supported and their relatives.

There were processes in place to ensure people were protected from the risks of abuse. People, relatives and staff had confidence the registered manager would deal with any concerns appropriately.

People were protected from the risk of infection as staff followed good infection prevention and control practices to reduce the risks.

People were able to have visitors and relatives told us they felt welcomed into the service.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The registered manager worked in an open way promoting choice and person-centred care for people. They led by example. People were encouraged to take part in resident meetings and give their opinion of the service via questionnaires.

Staff had received appropriate training to guide them in their roles and were supported with supervision and staff meetings.

The registered manager and their staff team worked with external health professionals to ensure people's needs were supported.

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 good (published 16 January 2020).

Why we inspected
This inspection was prompted by a review of the information we held about this service. We highlighted concerns around the management of risk and governance following our own monitoring processes. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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 COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.
The overall rating for the service has changed from Good to Requires Improvement based on the findings of this inspection.
We have found evidence that the provider needs to make improvements. Please see the Safe and Well-Led sections of this full report.

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 Victoria House on our website at www.cqc.org.uk.

Enforcement and Recommendations

We have identified breaches in relation to regulations 12 and 17 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to manage medicines in a safe way and the quality monitoring processes were not robust enough to identify the issues we found in relation to medicines, care plans and the environment at this inspection. Following our inspection, we received information from the provider to show they had addressed the concerns found at inspection.

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

Follow up
We will request an action plan from 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

continue to monitor information we receive about the service, which will help inform when we next inspect.

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 well-led?

Requires Improvement

The service was not always well led.

Details are in our well led findings below.

Victoria House Residential 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 Health and Social Care Act 2008.
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 team was made up of 2 inspectors.

Service and service type
Victoria House Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Victoria House Residential Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

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 who work with the service. We used all this information to plan our inspection.

During the inspection
We conducted 2 site visits as part of this inspection, on 21 and 23 November 2022.

We spoke with the director of the company registered to operate the care home ('the owner') who was also the registered manager; the deputy manager and 2 members of the care team. We also spoke with 5 people and 2 relatives about their experience of the care provided.

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 written records including 4 people's care files, 2 staff recruitment files and information relating to the auditing and monitoring of service provision.

After the site visits we reviewed further information we had requested from the provider.

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 our last inspection we rated this key question Good. At this inspection the rating has changed 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.

Using medicines safely

● People's medicines were not always managed safely. When observing a medicines round we found 2 tablets which should have been administered at the last medicines round. Staff told us the person had been asleep when the previous staff member had gone to offer the medicine to them, and they had left it in the trolley. This unsafe practice put people at risk of receiving medicines which had not been properly checked by the staff member who administered them.

● We viewed the controlled drugs register and found 1 person receiving a controlled drug had no records of when a new bottle of their medicine had been received and had no running totals of the amount that should be left. There were no running totals of other medicines in use. This lack of consistent monitoring processes put people at risk of their medicines being abused.

● There was a lack of protocols in place for 'as required medicines' to provide guidance for staff to ensure these medicines were administered to people safely. Skin patches containing medicines used as a pain killer, that should be kept in a controlled drugs cupboard, were kept in the medicines trolley. The medicines trolley should have been locked and chained to the wall when not in use. The chain was broken and no longer attached to the wall when we visited. This meant medicines were not always managed safely and in line with current guidance.

● There were a number of handwritten prescription entries on medication administration records (MAR's), which were not signed by staff to show they had checked the details had been accurately transferred from the original prescription sheet. This put people at risk of receiving medicines which may not have been accurately transcribed from the original prescriber.

These unsafe practices around the handling of people's medicines was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● Although the risks to people's safety had been assessed and there were measures in place to support people to reduce these risks, there was a lack of recording of some actions related to environmental risk. For example, there were stairgates in place at the bottom and top of the staircase but no risk assessments as to why this action had been taken.

● There was conflicting information in some people's records when there had been changes to their needs as some parts of their care plans had not been updated. Despite this, staff we spoke with were very knowledgeable about people's current needs.

● During our inspection we saw people had appropriate equipment to support them such as mobility aids and pressure relieving mattresses. One person who was at risk of choking had clear information in their care

plan on how they should be supported. We saw staff supported the person in line with their needs and in a dignified way.

Learning lessons when things go wrong

● Staff told us there was a lack of processes to help learning from events. They told us they talked about incidents between themselves but there was no formal way of recording and sharing events to improve outcomes for people.

Staffing and recruitment

● People were supported by sufficient numbers of appropriately trained staff. People told us staff responded to their needs in a timely way and they were happy with the care provided. However, the duty rota showed staff were working extra hours to cover shifts, and staff were required to take on multiple roles to ensure people were well cared for.

● Staff told us they could do with more staff and 1 member of staff said, "Feel like I have to cover shifts, so the residents are safe and supported." Staff told us the registered manager undertook extra shifts to ensure people were well supported and the staff roster reflected what we had been told. The registered manager told us they were trying to recruit more members of staff and when needed would use agency staff.

● There were safe recruitment processes in place to ensure people were supported by fit and proper staff. The staff files we viewed showed the application process and that references had been sought. The Disclosure and Barring Service (DBS) checks had been used before appointing staff to the service. The DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

● There were systems and processes in place to ensure people were protected from the risk of abuse. People told us they felt safe with the staff who supported them. Relatives supported this view. One relative told us the staff were very approachable.

● Staff we spoke with were aware of their responsibilities of protecting people from abuse. They had received safeguarding training and were able to tell us how they would manage any safeguarding concerns. They had confidence the registered manager would deal with any safeguarding concerns appropriately.

● Records showed when there had been a safeguarding concern raised the registered manager had worked with the local authority safeguarding teams to investigate issues raised.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

● The provider was still asking relatives to undertake a lateral flow test to reduce the risk of COVID-19 entering the service. The registered manager told us they had not had any outbreaks of COVID-19 at the service, and they were keen to maintain this. However, we saw people's relatives were able to visit their family members on a regular basis. Two sets of relatives told us they were able to visit when they wanted, and staff were welcoming towards them.

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 our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. 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

- Quality monitoring processes were not always robust. Some auditing tools used were not fit for purpose, some auditing processes were not in place and actions identified on some auditing processes had not been followed up. The lack of this consistent, effective oversight put people at risk of receiving unsafe care.
- The issues we highlighted around medicines management had not been highlighted by the auditing tools used resulting in shortfalls in the management of medicines. Although care plans were reviewed each month there was no auditing process in place to highlight areas of the care plans which needed improvement to ensure information was consistent.
- Environmental audits had been undertaken. However, the issues highlighted in the last environmental audit undertaken between March and May 2022, had not been addressed and there was no action plan in place to show the actions would be addressed.

The provider had not ensured effective governance of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- However, more positively, the registered manager regularly submitted statutory notifications to CQC about events at the service. Notifications are events which happened in the service that the provider is required to tell us about.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People were supported in a person centred and open way. People and relatives told us the registered manager and their staff promoted choice. For example, we saw some people chose to spend time in their rooms and others preferred the company of other people. When people spent time in their rooms, they had the things they wanted around them. One person was reading a large print book, and another person was watching a comedy programme and we could hear them laughing.
- Relatives were encouraged to interact with people and 1 relative had been painting people's nails and chatting to people. They told us this had helped their family member build relationships with other people at the service.
- Throughout our inspection the registered manager led by example by promoting positive interactions between the staff team and people.

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

● Relatives told us the registered manager was open and honest regarding events at the service. The registered manager understood her responsibilities around the duty of candour.

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

● The registered manager worked to ensure people, their relatives and staff were engaged and involved with the service. Relatives told us they were able to positively engage with the registered manager and staff. One relative told us, although their family member was visually impaired, the signage at the service had supported them to find their way around the home. We saw results of satisfaction questionnaires and minutes of resident meetings which had been produced in a clear, easy read format for people.

● Staff told us the registered manager was approachable and fair. We saw staff had received supervisions and minutes of staff meetings, which had just started up again following a break due to COVID-19. Staff told us they felt supported but as a small group they, including the registered manager, were working a lot of extra shifts to keep people safe.

Continuous learning and improving care; Working in partnership with others

● The registered manager told us they belonged to a local care association and used the CQC website to keep up to date with current practices. She shared this information with her deputy manager.

● The registered manager and her staff worked with external health professionals to ensure good outcomes for people's needs. Such as following the speech and language therapy (SALT) team's guidance, for people who required specialist diets and support due to difficulties in swallowing.

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 Unsafe practices around the handling of people's medicines

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured effective governance of the service.