Four Seasons Health Care (England) Limited

Victoria Care Home

Inspection report

Victoria Street
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Ratings

Overall rating for this service	Requires Improvement

Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 6 October 2016 and was unannounced.

We previously carried out an unannounced comprehensive inspection of this service on 30 June 2016. After that inspection we received concerns in relation to people experiencing weight loss while living at the service. Concerns were also raised regarding the communication between staff and people living with dementia. As a result we undertook a focused inspection to look into these concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Victoria Care Home on our website at www.cqc.org.uk"

The service had an overall rating of good at the last inspection, however the 'well led' domain was rated as requires improvement.

Victoria Care Home is located in the village of Rainford, St. Helens, providing nursing care and support for up to 53 residents. The service which is part of the Four Seasons Health Care Group, is a modern, purpose built facility with 46 single bedrooms, and six double bedrooms, set over two floors. The ground floor, Alexander unit accommodates people who require nursing care. The Edward unit on the first floor, accommodates people who require care and support with dementia and related conditions.

A registered manager was in post; however was on extended leave until January 2017. A temporary manager was in post to cover the period of absence. 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.

During this inspection on 6 October 2016 we found breaches of the Health and Social care Act 2008 (Regulated Activities) 2014.

During the mealtime experience upstairs we found people were not offered choice from the menu. Two people were being fed at the same time by one member of staff who offered very little positive interaction whilst carrying out this task. People told us they did not enjoy the meals. People were not offered a choice of sandwich fillings, were not told the flavour of the soup or asked whether they would like white or brown bread. The mealtime experience was not managed in a way that promoted a pleasant dining experience for people, while maximising their choice and control. People's perception and understanding of how to access food and drink was influenced by their level of independence.

We found essential records for the monitoring of nutrition and hydration were not fully completed which meant that staff could not be sure people had eaten enough food or drank enough fluids. This left people at risk of dehydration and malnutrition.

Staff on the first floor consistently demonstrated poor communication skills. For example people would ask a direct question and not receive a response. During times when people were in receipt of support to eat and drink, staff did not communicate with them at all. People and visitors that were able to share their experience stated staff were not always caring and support was variable.

The registered provider did not have robust auditing processes to highlight areas for development and improvement. We found systems that were in place were ineffective as they had failed to identify gaps within the record keeping procedures.

You will see what action we told the registered provider to take at the back of the full version of the report.

Visitors to the service and people living on the ground floor of the service reflected positively about staff and stated they were kind and caring.

Staff were up to date with the training required to undertake their roles and received regular supervision.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service effective?

Requires Improvement

The service was not always effective.

People's dietary needs were not consistently being met and they were not always offered choice. People did not always have a positive mealtime experience.

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

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

Is the service caring?

Requires Improvement

The service was not consistently caring.

Communication between staff and people living at the service with dementia was poor. Staff interactions did not always ensure people were treated with dignity and respect.

Some people and visitors to the service spoke positively about the support provided by staff and the relationships they had developed.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The quality assurance systems in place were not effective to highlight areas for development and improvement. Records were inconsistent and incomplete.

The registered provider had reported significant incidents to the Care Quality Commission in a timely manner.

Victoria Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 6 October 2016 and was unannounced.

The inspection team consisted of an adult social care 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. The expert by experiences speciality was dementia care and people living with dementia.

We looked in detail at the care planning records relating to three people living at the service. We spoke with 15 people living at the service and four visitors. We spoke with three members of staff, the temporary manager and the registered provider's area manager.

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.

Before our inspection we reviewed the information we held about the service including incidents the registered provider had sent to us since our last inspection.

Requires Improvement

Is the service effective?

Our findings

People said that the meals were variable. Quotes from people included, "It's so, so, it depends what it is", "I get bored with the same things to eat" and "Food is average most of the time". During lunchtime we observed people were not told the flavour of the soup and they were not offered a choice of sandwiches of tuna, cheese or ham. People were not offered a choice of white or brown bread although a choice was available.

People told us that they were offered drinks throughout the day. Their comments included, "We do get a drink between meals" and "The juice is from a machine and I don't know what the flavour is, staff just say it's out of the machine". People were observed being given a drink of juice at 11:15 AM however an alternative was not offered.

There was a stark contrast between the dining experiences of people living with dementia on the upstairs floor, and people who lived on the ground floor. Upstairs we observed poor interactions between people using the service and staff. For example, a member of staff was observed supporting two people to eat at the same time. This was not dignified. A member of staff was also supporting another person to eat, however there was no attempt at communication from the member of staff. When the person had finished eating, the member of staff just walked away. This was a task focussed experience, and was not person-centred.

In contrast we saw that the lunchtime meal experience in the dining room downstairs was much more positive. The dining room tables were set out appropriately and included condiments and serviettes. People were sat chatting and it appeared a social occasion. However in both dining rooms the menu was out of date and incorrect, which may lead people to become confused about their meal-time options.

During our last inspection in April 2016, we had raised concerns regarding the meal time experience in the upstairs dining room and had received assurances from the registered manager and the area manager that this would be addressed. The contrast between the two dining experiences highlighted a lack of knowledge and compassion by staff towards people living with dementia.

We visited people that were care for in their bedrooms and found that although cold drinks were available to them, they could not readily access them due to being in bed. We saw hot drinks had been delivered but had been left to go cold. One person's daily record's chart showed no drinks recorded from teatime the day before. This meant the person was at risk of dehydration.

This was a breach of and Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not consistently treated with dignity and respect.

Some people had been assessed as requiring food and drink charts to be completed within their rooms. These had not been consistently completed with total food and drink offered and consumed. This meant people were at risk of becoming dehydrated and malnourished.

People being cared for and supported within their own rooms had been assessed to be checked regularly to ensure their needs were being met. We found records to be inconsistent with significant time lapses between checks. For example when visiting a person in their room at 11:25 AM hourly checks had not been recorded since 9:30 AM. This was immediately raised with the nurse in charge. On revisiting the person at 14:25 PM the hourly checks had not been completed since 11:28 AM. Another person was visited in their room at 11:30 AM and no hourly checks had been logged since 6 AM. This meant the registered provider was not following their own risk assessments and documentation.

This was a breach of and Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not being regularly checked in accordance with their care assessments.

The Mental Capacity Act 2005 (MCA) provides a legal framework 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 on helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the deprivation of liberty safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met and found that they were. The registered manager had an knowledge of their responsibilities in relation to the MCA and people who required a DoLS had one in place, or were waiting to be assessed. This meant that people's rights and liberties were being upheld in line with the law.

Training records reviewed showed that all staff had received training in the MCA. Staff spoken with demonstrated a good understanding of the MCA. Staff reflected that all people must be given the opportunity to make basic decisions and choices. They understood the necessity for acting in people's best interests at times.

One person took their sock off to show us their sore toe. We noticed that their toenails were extremely long and in need of cutting. We immediately raised this issue with the nurse in charge who stated they would arrange a visit from the chiropody service. Records showed this person had not received a visit from the chiropody service since January 2016.

Records showed staff were up-to-date with training required for their role. Training undertaken included safeguarding, basic life support, health and safety, equality and diversity and medicines management. People told us that they thought the staff were trained to do the job. Their comments included, "Yes, they're pretty good" and "I'm sure they are, they're very attentive".

Staff had undertaken comprehensive dementia care training and had been assessed as being competent. However we observed skills and knowledge were not being fully utilised within the dementia care unit to ensure people had a positive experience.

Staff told us and records demonstrated they received regular supervision in their roles. The registered nurses received regular clinical supervision. The registered provider demonstrated staff were supported in their role.

People told us they had access to health care professionals including district nurses and GP and records

confirmed this.

Requires Improvement

Is the service caring?

Our findings

People living downstairs at the service told us, "Staff are nice and friendly", "Staff are nice, no problems, they do a good job" and "Staff treat me well, no problems". However people living upstairs stated "Staff walk past me and do not speak. I asked to speak to someone about a problem I had and they never came back" and "Staff take no notice of my likes and dislikes".

Visitor's comments included "All the carers, every one of them is brilliant", "They have always looked after mum very well. I always get a phone call to inform me of any changes" and "I'm very happy with the home, staff are caring, very kind and I always get offered a cup of tea".

We observed four people upstairs who were walking around with just socks on their feet. This was pointed out to a member of staff and they told us the people took their slippers off. However within one hour three of these people had slippers on their feet and these remained in place throughout the day.

We asked people if they had a good quality of life at the home and what made it good. Responses from people downstairs who were able to communicate with us included, "Yes, I like the singing and dancing", "I think it's nice" and "We have a laugh". A visitor to a person living downstairs said "I think so, the staff make it good. My relative enjoys chatting to staff and other people living here". We observed a very lively, fun and interactive game of bingo during our visit. Everyone that wanted to participate was supported to do so by staff or visiting relatives. Responses from people who we spoke to upstairs who were able to answer included "I can't say yes or no" and "No I don't have a good quality of life, I can't do anything". A visiting relative upstairs said "No it's not good activity wise, they just leave the people who can't do much".

Throughout our observations upstairs we noted that staff on the first floor did not always engage in a kind or friendly way towards the people they were supporting. For example staff walked past people without speaking to them on numerous occasions throughout the day, even when people asked them a question. We saw a member of staff assisting a person with a drink during the morning and they stood over the person and did not speak to them. The date on the notice board upstairs was two days out of date, which could be disorienting to people. When this was highlighted to a member of staff they immediately changed it. This did not demonstrate a kind or caring approach.

The registered provider had introduced a care initiative titled 'Dementia Care Framework'. At our last inspection we were told that the care initiative was planned primarily for the first floor of the service and would include: improvements to the environment, training for staff on the experiences of people using the service, the use of music to support people and integrating people's rights into their everyday care experience. The aim of the project was to ensure that people living with dementia received a person centred approach whilst living at the service. Records showed that all staff working on the first floor had completed this training. Our observations did not highlight a positive experience for people living with dementia on this floor.

Following our inspection the registered provider forwarded an action plan highlighting that the dementia

training specialists would be immediately revisiting the service to work with the staff and management team to improve the experience of people living with dementia at the service.

During our observations downstairs we saw positive staff interactions. Staff were seen to be caring in their approach, taking time to understand a person's needs and talking in a clear but gentle way. There was lots of laughter throughout the day and relationships appeared to be well established between people and staff. The atmosphere was friendly and welcoming. Visitors to the home were seen to be welcomed and interacted with all people living at the service.

People told us they were able to furnish their rooms with personal items including small items of furniture, photographs and ornaments. All rooms had been fitted with window blinds to protect people's privacy and dignity during personal care routines. One person told us that staff always ensured their door was closed and they were given as much privacy as possible during personal care.

Care plan records included end-of-life information where people had specified this. One care plan showed that a person had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place which gave clear instructions regarding their choice. Some people had made advanced decisions regarding their end-of-life choices and this was clearly documented within the care plan records.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager who had been registered with the Care Quality Commission since October 2015. Prior to taking up the position they had worked at the service for several years. The registered manager was on extended leave at the time of our inspection and a temporary manager had commenced in post that week.

The registered provider was unable to demonstrate robust auditing procedures to highlight areas for development and improvement. Systems in use were not always effective. For example the charts used within people's bedrooms to log monitoring checks that had been highlighted as required through risk assessment were not fully completed. Environment audits had not highlighted timescales for improvements regarding the dementia care environment.

The registered provider had an audit system in place to regularly review care plans, medication and accidents and incidents. They did not have effective systems in place to review records completed within people's rooms. These records documented people's regular safety checks and if people had received food and drink.

The internal audit system had not highlighted that a person should have been having weekly blood sugars undertaken and these had discontinued without explanation or authority from the GP. This was immediately addressed on the day of our visit.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider did not have an established system or process in place to enable them to assess, monitor and improve the quality and safety of the service provided in the carrying on of the regulated activity.

Many people living at the service had raised concerns regarding the meals available; however this had not been addressed in a timely manner. People had complained about the quality of the food, the temperature and the choice over an extended period of time. The issues highlighted were being addressed and some people commented positively on an improvement.

The staff knew who their line managers were and stated they were able to seek support as and when required seven days a week.

People living at the service were in the process of being introduced to the temporary manager. They were to cover the extended period of leave of the registered manager. People told us they would feel confident to raise concerns.

The registered provider had a set of visions and values in place that promoted peoples wellbeing and independence. Whilst some staff demonstrated they were aware of these values and worked to promote them in their day to day work; we saw that other staff did not demonstrate these values. We observed staff

working in a person-centred way and some staff worked in a task focused way. The registered provider showed a commitment to making improvements and immediately following our inspection shared an action plan identifying areas that required improvement. The action plan identified who was responsible for each action with a timescale for completion.

The registered provider had notified the Care Quality Commission (CQC) promptly of all significant events which had occurred in line with their legal obligations. Registered providers are required to inform the CQC of certain incidents and events that happen within the service.

The registered provider had policies and procedures in place that were up-to-date and accessible to all staff.

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 10 HSCA RA Regulations 2014 Dignity and respect The registered provider must ensure that people are treated with dignity and respect by staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider must ensure care and treatment is provided in a safe way for people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider must ensure that robust systems are in place to monitor and assess the quality of the service being provided.