Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Victoria Lodge Residential Care Home

138 Thorne Road, Edenthorpe, Doncaster, DN3 2LU

Tel: 01302884806

Date of Inspection: 15 March 2013

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We inspected the following standards to check that action had been taken to meet them. This is what we found:

Care and welfare of people who use services	✓	Met this standard
Management of medicines	✗	Enforcement action taken
Records	✓	Met this standard

Details about this location

Registered Provider	Mrs Saima Raja
Registered Manager	Mrs. Sara Tamar Bennett
Overview of the service	Victoria Lodge provides care for 24 older people. It is situated on the outskirts of Doncaster in the area of Edenthorpe. It provides accommodation on both the ground and first floor and has parking to the front of the building and a secure accessible garden at the rear.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

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When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

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Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Victoria Lodge Residential Care Home had taken action to meet the following essential standards:

- Care and welfare of people who use services
- Management of medicines
- Records

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 15 March 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, were accompanied by a pharmacist and reviewed information sent to us by commissioners of services. We talked with commissioners of services.

What people told us and what we found

During our visit we spoke with seven people who received a service, five relatives and six staff. People told us they could see the service had improved and relatives agreed that there were many improvements. They also told us staff were more approachable and listened and followed through any actions required. This ensured their relatives needs were met.

During our visit we spent time observing in the lounge and dining room. We observed good interactions between staff and people who received a service. There were activities ongoing at the time of our visit and people were joining in and enjoying the activity and interaction.

People who lived in the home had a diagnosis of dementia and did not know, or were unaware of what medicines they were prescribed. This meant that they were unable to talk to us about their medicines in a meaningful way.

We looked at care records and found that people's personal records including medical records were accurate and fit for purpose.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have taken enforcement action against Victoria Lodge Residential Care Home to

protect the health, safety and welfare of people using this service.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

At our visit in February 2013 we identified major concerns with this outcome and issued a warning notice. This visit was to determine compliance with this outcome.

At this visit we found people's needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

We looked at three care plans and found them to be sufficiently detailed to enable staff to deliver the correct care to people. We spoke with six care staff to assess their understanding of the care being delivered. The staff were able to tell us that they had responsibility to complete daily records, which described the care and treatment given to people who used the service. The staff told us that if people's care needs changed, they would complete the necessary documentation and inform the senior care worker or the acting manager. This would ensure the appropriate advice was obtained and the person's care and treatment plan was updated to reflect the changes. The acting manager told us that the care plans had been reviewed to ensure all people's needs were identified. However they would commence person centred plans for people so they were more individualised and detailed people's choices and decisions.

We found the care plans had been reviewed and updated since our last visit. The plans contained sufficient detail to enable staff to evaluate the person's care. We found risk assessments in relation to moving and handling, falls, pressure care and nutritional assessments. They had also been updated since our last visit. The risk assessments gave staff information about how to deliver care and treatment to people. Staff told us that they also had responsibility for updating assessments which helped to evaluate the care given to people.

We observed staff using moving and handling equipment appropriately, which was described in people's care plans. We saw examples of where the district nurse had been involved when staff had identified an injury to a person's leg. We also saw evidence that staff had referred people to the dietician when required. We found records which

confirmed people received sufficient food and drinks to meet their needs. We looked at the fluid charts for one person who required a fortified diet. The records confirmed the person's nutritional needs were being met.

Staff told us that they had opportunities to read the plans of care. They said changes to people's care needs were discussed daily. And the communication between staff had improved since the new acting manager had been in post.

Management of medicines ✖ Enforcement action taken

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

We have judged that this has a moderate impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

We looked at the systems in place for managing medicines in the home. This included the storage and handling of medicines as well as a sample of Medication Administration Records (MARs), stock and other records for 11 people living in the home. Overall, we found that appropriate arrangements for the recording, administration and safe handling of medicines were not in place.

Medicines were kept securely in a locked trolley. Appropriate arrangements were in place to order new medicines and to safely dispose of medicines that were no longer needed.

We found errors, missing signatures or other discrepancies on all the medicines records that we looked at. Some care workers had not always signed for medicines they had given, and had failed to record the reason why other medicines had not been given as prescribed. We also saw that some care workers had signed for the administration of medicines at times when no dose was due. We saw three handwritten medicines records where the date, person's details and allergies were missing and one example where the strength and dose of medicine had been recorded incorrectly. Records showed that care workers were not applying creams and ointments as often as they should. People living at the home are at risk of harm when medicines records are not accurately maintained.

We found that medicines were not always given as prescribed. We saw that inhalers were not always given as often as they should have been and we found eight examples where tablets had been signed for as given, even though the tablets were still present in the packs. We saw that one medicine that should have been given three times a day was only actually being given once or twice a day. We found that when people were asleep at the time of the medicines round, care workers did not generally return and reoffer the medicines when the person was awake. Staff also did not in the case of night time medicines, make arrangements to ensure that they were offered before the person went to bed. People living in the home are at serious risk of harm when they are not given their

medicines as prescribed.

A check of stock and records showed that two people had been given more medicine than they were prescribed. The correct doses were clearly recorded on the medicines records and labels and there was no explanation for why extra medicine had been given. Giving people too much medicine may seriously harm their health and well being.

Many people living in the home were prescribed medicines to be taken only, "when required" for example painkillers and laxatives. There was little or no information for care workers to follow in order to ensure that the medicines were given correctly and consistently with regard to the individual needs and preferences of each person. Some people had difficulties taking tablets and arrangements were clearly in place to support these people to take their medicines safely. Care workers did not always follow these instructions resulting in doses being omitted unnecessarily.

Medicines were supplied in a blister pack system that had only recently been introduced into the home. All senior care workers had received training on the new system, but had yet to undertake assessments to ensure they were capable of handling medicines safely. Care workers covering night shifts had not had medicines training and did not administer medicines. This meant that there were no arrangements in place for people to be given their medicines, for example painkillers overnight should they be needed.

The recently appointed acting manager had not yet completed any formal medicines audits (checks); however she had identified some poor practice and discrepancies and had already made arrangements to address these issues with the care workers responsible. As a result of our findings, the acting manager took immediate action to ensure that medicines would only be administered by those senior care workers whom she had assessed as competent to handle medicines safely.

Records ✓ Met this standard

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was meeting this standard.

People's personal records were accurate and fit for purpose.

Reasons for our judgement

At our visit in February 2013 we identified major concerns with this outcome and issued a warning notice. This visit was to determine compliance with this outcome.

At this visit we found people's personal records were accurate and fit for purpose.

We looked at three people's plans of care. We found people's needs had been reviewed and updated and clear guidance was in place on how to meet their needs. We also saw that the care needs were regularly reviewed. Staff we spoke with were knowledgeable about people's needs and how to meet them.

The acting manager told us that all the care records had been reviewed; however the plans were not person centred or individualised. We were informed by the acting manager that all people's plans would be rewritten so they were individualised incorporating people's choices and decisions. The provider had produced an action plan, which detailed the timescales for completion of the care records.

The care records were kept securely and easily located when required. The staff told us that they were able to have more input into the records since the new acting manager had been in post. This meant they were able to update the care records when any changes occurred to people's needs. This ensured people's records were maintained, up to date and accurate.

Overall we saw significant progress, however we did identify some issues with documentation when we looked at medication. We have addressed these points in management of medicines outcome 9.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 12 April 2013 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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