Victoria House (Wallasey) Limited

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Inspection report

166 Church Street
Wallasey
Merseyside
CH44 8AL

Tel: 01516387863

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Victoria House on 26 June 2018. The inspection was unannounced. Victoria House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to accommodate up to 56 people in adapted four-storey premises, and 50 people were living there at the time of this inspection.

Our last inspection of the service was on 8 March 2016, when we found that the service was good in four areas but required improvement in the 'effective' domain. We found a breach of Regulation 11 of the Health and Social Care Act 2008: need for consent, because not all staff had received training about mental capacity and consent, and arrangements for the covert administration of medication were not compliant with the requirements of the Mental Capacity Act 2005. During this inspection we found a continued breach of Regulation 11.

We found a breach of Regulation 18 of the Health and Social Care Act 2006: staffing, because not all staff had completed the provider's comprehensive programme of training to ensure that they knew how to support people safely.

There was a breach of the Care Quality Commission (Registration) Regulations 2009: Regulation 18 because the provider had failed to notify CQC of occurrences at the home.

There was also a breach of Regulation 17 of the Health and Social Care Act 2006: good governance, because the provider did not have effective governance, including assurance and auditing systems or processes, to identify where improvements were needed.

The home is required to have a registered manager. 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. The home had a registered manager who had been in post for several years.

The care files we looked at showed that people's care and support needs were assessed covering their health and personal care needs and plans were written for the care and support people needed. These were kept up to date with monthly reviews. We found that the care plans lacked person-centred detail and some inappropriate language was used.

The home was clean and there were no unpleasant smells. Some improvements had been made to the environment since our last inspection. Maintenance records showed that regular checks of services and equipment were carried out by the home's maintenance person and testing, servicing and maintenance of utilities and equipment was carried out as required by external contractors.

People had a choice of spacious sitting areas on the ground floor. These included a 'garden lounge', which was a quiet area with no television; a 'ballroom' where activities took place; a smokers' lounge; and a conservatory. People were free to walk around and choose where they wanted to spend their time.

Medicines were stored safely and people received their medication as prescribed by their doctor.

There were enough qualified and experienced staff to support people and meet their needs, and people we spoke with considered there were enough staff. Staff had received training about safeguarding vulnerable people from abuse.

Risk assessments were recorded in people's care notes and plans put in place to reduce the risks identified. A log of accidents and incidents was maintained.

People told us they enjoyed their meals and had plenty to eat and drink.

People who lived at the home told us that the staff provided them with good care and support and we observed that staff treated people with kindness and respect. People we spoke with described the staff as kind and caring and we observed positive and respectful interactions between staff and people who lived at the home. People told us they enjoyed the activities and trips out.

Regular meetings were held for staff and for people living at the home. The staff we spoke with told us they enjoyed working at the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The home was clean and adequately maintained.

There were enough staff to support people and keep them safe. The required checks had been carried out when new staff were recruited.

Medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not entirely effective.

Deprivation of Liberty applications had been submitted for some people, however arrangements for the covert administration of medication were not compliant with the Mental Capacity Act 2005.

There were some significant gaps in staff training.

People received enough to eat and drink.

Is the service caring?

Good

The service was caring.

We observed staff caring for people with dignity and respect.

People who lived at the home, and their relatives, told us that the staff were kind and caring.

People's personal information was kept confidentially.

Is the service responsive?

Requires Improvement

The service was mainly responsive.

People had choices in daily living and staff were aware of people's individual needs and choices.

The care plans we looked at recorded people's support needs and the care they received but were not written in a person-centred style.

A programme of social activities was provided.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service had a registered manager. The manager had not informed CQC of significant events as required.

Regular meetings were held for staff and for people living at the home.

Regular checks and audits were carried out but were not always in depth and had not identified the areas for improvement we found during the inspection.

Victoria House (Wallasey)

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. The inspection took place on 26 June 2018 and was unannounced. It was carried out by an adult social care inspector.

Before our inspection we looked at the information we held about the home, including the Provider Information Return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications of incidents that the provider had sent us since the last inspection. We contacted Wirral Council's Quality Monitoring and Contracts department to ask for their comments.

During the inspection we looked at all parts of the premises. We spoke with eight members of staff, four people who lived at the home, and three visitors. We observed staff providing support for people in the lounges and the dining rooms. We looked at medication storage and records. We looked at staff rotas, training and supervision records, and recruitment records. We looked at maintenance records. We looked at care records for four people who lived at the home.

Good

Is the service safe?

Our findings

The home was clean and well maintained. The most recent NHS infection control audit scored 96% which had improved from their previous inspection. The kitchen currently had a four star food hygiene rating. A water hygiene log book recorded that regular Legionella tests were carried out. There were also records of monthly temperature checks of hot and cold water outlets and shower heads sterilisation.

Radiators had protective covers to prevent the risk of burns. There were padlocks on the storerooms containing cleaning products. There were door-guards on bedroom doors so that people could have their bedroom door open without presenting a fire risk. Certificates and records were in place to show that checks had been carried out on the lifts, moving and handling equipment, small electrical appliances, the fire alarm and emergency lighting systems, and the gas and main electrical systems.

A fire risk assessment was in place and included an emergency evacuation plan to local premises. There were individual emergency evacuation plans for people who lived at the home and copies of these were kept in a folder in the main office by the front entrance. Most staff had undertaken fire training, however this was several years ago for many of them and the registered manager told us that fire training was booked for September.

People we spoke with, including members of the staff team, thought there were enough staff on duty to provide the care and support people needed. During the inspection we observed that there were always staff around in the communal areas to support people and any spillages were dealt with promptly. We noticed that people had call bells close by them so they could attract the attention of staff when needed.

In the PIR, the manager told us "We have current contracts with several agencies and have signed the appropriate contracts with them. We keep a register of those who work here from the agency with their pen pictures/profiles and provide regular feedback to agencies as requested." During the inspection we saw evidence of this.

In addition to the staff who provided direct care, the home had an administrator, a full-time and a part-time maintenance person and a part-time minibus driver. A cook worked between 8am and 5pm supported by a kitchen assistant in the morning and evening. Four housekeeping staff were employed for cleaning and laundry duties. The manager told us that there was a low turn-over of staff.

We checked the personnel files for three care workers. They had completed an application form and been interviewed before being offered employment, although interview notes were not kept. Two references had been provided for each, however for one these staff members, both references had come from family members. We asked the manager about this and he was able to provide a satisfactory explanation. All staff had a Disclosure and Barring Service check, however some of these were several years old and the manager had started applying for new disclosures.

Medication was administered by senior care staff who had completed appropriate training and competency

checks. We saw that staff carrying out medicine administration wore 'Do not Disturb' tabards. These helped to reduce interruptions which can increase the risk of errors. Most medication was given to people in the dining room and staff ticked off names on a printed list to make sure no-one was missed.

Most medicines were supplied in a cassette system. These were stored securely in two cupboards. Additional storage for medication not in current use was provided in a clinical room.

A separate sheet in the medication administration record (MAR) file showed the specific indications for use of an 'as required' medication. Care staff wrote relevant comments on the reverse of the MAR, such as why the medication had been needed. We saw that MAR sheets were well completed with no missed signatures.

Medicines were generally well managed, however we noticed some items stored in the drugs fridge that did not need refrigeration. This included micro-enemas which could be unpleasant for the person receiving them if administered cold. We brought this to the attention of the senior care staff who were responsible for the storage of medication.

Risk assessments were included in people's care notes and were updated monthly. Accidents and incidents were reported and recorded and were reviewed monthly by the manager. We saw equipment in place to help keep people safe, for example alarm mats and various types of mobility aids.

Staff working in the home had received training about safeguarding vulnerable adults from abuse. A serious incident that occurred in 2017 had been dealt with well by the home's staff and showed that they understood their responsibility with regard to safeguarding.

Requires Improvement

Is the service effective?

Our findings

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 Act 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 MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

At our last inspection we found a breach of Regulation 11 of the Health and Social Care Act 2008: need for consent, because not all staff had received training about mental capacity and consent, and arrangements for the covert administration of medication were not compliant with the requirements of the Mental Capacity Act 2005. Since our last inspection, care staff had received training about the Mental Capacity Act and DoLS, and files were in place containing copies of mental capacity assessments and DoLS applications where made.

We found little information in people's care plans regarding the decisions people were able to make in daily living and where they needed support. We saw consent forms that had been signed by relatives without evidence that the relative had a Power of Attorney giving them a legal right to do this. The consent forms included consent for staff to open people's mail. We asked the manager about this as it appeared to be an infringement of people's rights. He explained that the intention was to ensure staff were aware of any medical appointments.

We saw some people were given medication covertly. Covert medication is the administration of any medical treatment in disguised form. This usually involves disguising medication by administering it in food and drink. We looked at records for two people receiving medicines covertly at the home. Both had a letter from their GP agreeing to this practice. However, there was no list of medication and no evidence that a pharmacist had reviewed the people's medicines in relation to giving them covertly. This is important because some preparations should not be crushed and mixing medicines in different food might affect their effectiveness. We did not see care plans in place for the administration of covert medication.

We also noticed that one person had a restraint in place to prevent them falling from their chair but we saw no details in their care plans to show how this had been decided on and who had been consulted.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Need for Consent. □

The training records provided did not show that new staff received an induction when they started working at the home. The manager told us that care staff with little or no previous experience of care had undertaken a period of shadowing senior care workers before working alone but we did not see any records of this. However, the records showed that all of the care staff had a national vocational qualification or had

completed the Care Certificate, and some were working towards a higher level qualification.

The provider subscribed to a programme of on-line training, however uptake of this was patchy. Only three seniors and three care staff had completed the training about food hygiene although they were involved daily with supporting people with food and drink. Less than half of the seniors and care staff had completed the training about nutrition and hydration. Only three of the care staff had completed the falls awareness training.

Thirteen care staff had no date recorded for moving and handling training, and nine had no date for fire training. This included two seniors who may be in charge of the home and take lead responsibility in the event of a fire. We discussed our concerns with the manager who told us that practical training for fire safety, moving and handling and first aid was booked for September 2018 after the main holiday months.

This is a breach of Regulation 18 of the Health and Social Care Act 2016 because the provider had not ensured that staff received the training necessary to enable them to carry out the duties they are employed to perform.

Staff had regular supervision meetings and an annual appraisal. Supervision provides staff and their manager with a forum to discuss their training and support needs, any concerns that they may have and how they are performing in their job role. The manager told us that the supervision sessions took into account different questions around topics within the policies and procedure file.

People told us they had enough to eat and drink throughout the day and night and that the food was good. One person told us "I'm a faddy eater but [cook's name] always gets me something I like." The home used prepared frozen meals that were made for care homes and the cook told us the system worked particularly well for people who had special needs, for example a soft or pureed diet. The system had been in place for over two years and the cook told us she had learned how to adapt it to suit people's needs and preferences. She also made additional meals that people particularly liked, for example 'Scouse'.

We observed that people had their breakfast at different times during the morning depending on when they got up. They were asked what they would like and could have a cooked breakfast if they wished. At lunchtime, people who needed some support with their meal sat in the smaller dining room and were helped by the care staff. People were asked what they wanted for lunch, there was a choice of sandwiches, soup, or a light cooked meal. The main meal was served later in the day.

People's weights were monitored monthly and recorded in their care plans. In the PIR the manager told us "We monitor weight monthly and keep appropriate records. Contact is then made with the GP and our concerns passed to the dieticians - a plan is then agreed with the resident (where possible) and fortified foods or drinks monitored with reviews by the dieticians until the resident's weight stabilizes or further investigations reveal other treatments required."

However, we noticed that one person had gained weight each month and had a high BMI which may be impacting on their health and mobility. We did not see any evidence that this had been recognised as a high risk and staff had recorded each month that the person had a good appetite.

On the ground floor, people had a choice of spacious sitting areas which were all on the same level. These included a 'garden lounge', which was a quiet area with no television; a 'ballroom' where activities took place; a smokers' lounge; and a conservatory. All had been decorated and furnished to a good standard and provided room for people to move around and choose where they would like to spend their time. There was

also a shower room on the ground floor which was accessible for people with mobility difficulties, and toilets had wide doors which would accommodate wheelchairs.

There was a well-maintained patio garden at the back of the house but it was not secure for people to use unsupervised and it was not accessible from any of the communal areas. This meant that people who wished to use the garden had to be accompanied by staff or by their visitors. Some people liked to sit at the front of the building and told us they enjoyed seeing people passing.

Bedrooms were on the first and second floors. A programme of redecoration and refurbishment of bedrooms had continued since our last inspection. In the PIR, the manager told us "We plan to offer further choices of bathing facilities on the first floor with the design of another walk in wet room. This will allow more people to have their preferred choice quicker. We are always decorating areas of the home to ensure the residents here love the environment that they live in and that it is stimulating for them." We observed that most of the bathrooms on the first and second floors were not adapted for people with disabilities and appeared to be unused. We saw equipment in use in people's bedrooms including hoists, pressure relieving mattresses, bed levers and alarm mats.

Records showed that people had home visits from health professionals including district nurse, community matron, chiropody, GP, dentist, dietician, and were supported to attend medical appointments. Some of the people who lived at the home were living with dementia and received support from community mental health services. Staff used a daily list of professional appointments to record visits from doctors, nurses, or other health professionals. These included the reason for the visit, the outcome and any resulting changes in the person's care plan. This was used to handover to the next shift, update individual records and then passed to the manager to keep him updated.

Good

Is the service caring?

Our findings

People living at the home told us "The staff are really nice.", "I have a good laugh with the staff." and "I've got no complaints about anything." A visitor told us "My friend has been here for a few months and has no complaints. She seems happy and the staff are polite and friendly." Another visitor we spoke with was not happy with the home and had made complaints which we saw had been addressed.

We observed people being supported in the communal areas. All members of staff supported people in a friendly, caring way and greeted them with their name. The staff were patient and kind when dealing with repetitive questions. It was evident that the staff were very familiar with each person's likes and dislikes and how they liked to spend their time.

We saw that people were encouraged to be as independent as possible and were provided with appropriate mobility aids as needed. Some people told us they had a key to their bedroom door.

The manager shared with us a number of Thank You cards that he had received from people's families. These referred to the kindness of the staff when caring for their loved ones.

In the PIR, the manager told us "We have at the home senior staff who act as dementia and dignity champions, able to help new and other staff understand and review their working practices within the home. Diversity and inclusion is part of our culture here at the home and this can also be found as a foundation to our policies. I believe when assessing residents or interviewing potential staff that I apply all human right principles with dignity as those who are my friends and family would wish to be treated."

The manager told us how they supported one person who lived in the local community. The person requested a short stay at the home when they needed some support and company and then returned home. This had happened several times during the last year.

The manager told us they had close links to a local high school that provided gifts for Christmas and held monthly social afternoons for people living at the home to visit the school. He had received two phone calls this year from members of the public who commented on the positive way that staff supported people when out in the community.

There were no visiting restrictions and visitors were always offered refreshments. Some family members accompanied their relatives on trips and outings. The manager told us that some relatives of people who had lived at the home continued to visit them at special times, for example helping to put up Christmas decorations. He considered "They still feel they have a bond with the home. To me this is a wonderful reflection for the staff as to the care we give." Communion was offered every Friday by local clergy.

An information leaflet about the home and the services provided was available and was written in a clear and accessible style. In the PIR, the manager told us "When our residents now attend hospitals or appointments we have introduced a hospital passport that they take with them to help staff at the

appointment understand and relate to their needs."

We saw that records relating to people living at the home were stored and managed appropriately to ensure their confidentiality was protected.

Requires Improvement

Is the service responsive?

Our findings

People living at the home liked to get up at different times in the morning. Care staff helped people to wash and dress and escorted them to the dining room. We saw people chose to spend their day in different areas of the home which had different atmospheres. A small number of people chose to spend their day in their bedroom. The care staff we spoke with had a good knowledge of people's individual care and support needs.

Charts that recorded specific care provided for people were well completed by the care staff. People at risk of pressure damage were checked regularly by district nurses and equipment provided to reduce risk.

We looked at a sample of people's care files. The care files contained assessments that had been completed before the person went to live at the home. Assessments had been carried out by a senior member of the home's staff and there was also information from social services.

The care files contained personal details, a list of medication, medical information from their GP, a personal history and life story. There were risk assessments covering areas such as nutrition and falls, and records showing that people's weight and blood pressure were monitored. The plans for people's care had been kept up to date.

We noticed repeated phrases in people's care plans that were generic rather than person-centred and lacked detail about how individual needs and choices were supported, and how they liked their care to be given. For example, whether they preferred a bath or a shower, how often, and at what time of day. We also saw some disrespectful language used in care plans and brought this to the attention of the manager. We recommend that the provider seeks advice on how the care plans can be improved and made more person-centred, for example from the Social Care Institute for Excellence.

There was an activity programme that covered a wide range of interests and people were encouraged to join in if they wished. The home had a mini bus and trips out were organised twice a week. Other activities included poetry reading; reminiscence; art classes; skittles; bean bags; Velcro dart board; entertainment twice a month; school involvement, both primary and secondary; pamper afternoons; bingo and musical bingo. The small lounge was currently the "football room" and had been decorated for the World Cup. People told us they were enjoying sitting in there watching the matches.

The home's complaints procedure was available. We noticed that it did not give the names of, or contact details for, the manager or the provider. We brought this to the attention of the manager and following the inspection he added the required information. We looked at the complaints records kept by the manager which showed had complaints had been investigated and dealt with appropriately.

The home had achieved the recognised award Six Steps for end of life care. This aims to enhance end of life care through facilitating organisational change and supporting staff to develop their roles around end of life care. In the PIR, the manager told us "We have qualified for end of life care certification, however currently

this has expired but we will work towards getting it back. We have held meetings with families over such topics as end of life - providing support and information around Wills." At the time of our visit nobody was receiving end of life care at the home.

We checked whether the provider was following the Accessible Information Standard. The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand and any communication support that they need. In the PIR, the manager told us "We have used a local library service that has offered large print books and audio tapes. We have allowed families who do not have computer access at home to use facilities here to access information that may support their loved ones such as benefits and appointments, contact solicitors or the local authority etc. We have provided residents with picture guides for those with the onset of dementia as a tool to see if this helps them recognize symbols or pictures of what it is they are trying to explain to us."

Requires Improvement

Is the service well-led?

Our findings

The home had a manager who was registered with CQC and had been in post for several years. The manager told us that he attended the managers' meetings with the local authority and CQC. He also said that they were registered with companies who provided care updates via brochures or magazines.

The registered provider is required by law to display their current CQC rating in a prominent place within the service. During the inspection we observed that a summary of the home's last CQC inspection report was displayed on the premises, however it was not referred to on the provider's website. The manager arranged for this to be done immediately.

The registered provider is required by law to notify the CQC of specific events that occur within the service. Prior to the inspection we looked at notifications that had been submitted by the manager and found that CQC had not been notified of authorised DoLS applications or of safeguarding referrals that had been made to the local authority. The manager said he was not aware that these notifications were required. This meant that CQC was not able to accurately monitor information and risks regarding the home. Following the inspection, the manager sent us notifications of DoLS that were authorised for people living at the home.

This is a breach of the Care Quality Commission (Registration) Regulations 2009: Regulations 18 because the provider had failed to notify CQC of occurrences at the home.

The manager provided details of when meetings for staff and people who lived at the home had taken place. Staff meetings were held three monthly, with additional meetings for senior staff. The most recent meeting had been held on 12 June 2018 and was well attended. In the meeting, the manager had commended staff for end of life care they had provided, but expressed his disappointment with the take up of on-line training. The minutes of the meeting did not record any comments by staff.

The staff we spoke with told us they enjoyed working at the home. One member of staff told us they had worked on nights for a long time but were enjoying working during the day and being more involved with everything that went on in the home.

Meetings for people living at the home were held every two months. The meetings mainly focussed on social activities and where people would like to go for trips out. A bi-monthly newsletter was produced and there was a large board in the main corridor showing the week's social activities. An annual quality assurance survey was carried out and the feedback received was analysed by the manager.

The home is owned by a local GP who visits regularly and completes an 'owner report'. The manager told us he had six monthly planning meetings with the owner and their accountant. In the PIR, the manager told us of plans for future development. This included "further attention to detail around the home, a new walk in shower, the foyer being re carpeted and the last of the old windows replaced".

We saw that the manager carried out some monthly checks and audits. Finance audits were carried out and

recorded to ensure people were protected from financial abuse. A monthly accident audit was recorded and records of untoward incidents were well-maintained. The housekeeper maintained daily cleaning schedules but we did not find evidence of internal infection control audits.

Care plan audits consisted of ensuring that planned monthly reviews had all been carried out. A monthly medicines audit consisted of counting the numbers of tablets supplied in the cassette system, how many had been given, and how many were returned to the chemist at the end of the month. It did not check the count of medicines prescribed to be given PRN, and there was no recorded audit of MAR charts.

This is a breach of Regulation 17 of the Health and Social Care Act 2006: Good governance, because the provider did not have effective governance, including assurance and auditing systems or processes, to identify where improvements were needed, for example with regard to staff training, care plans and medication storage.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify CQC of occurrences at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Records kept at the home did not show how decisions had been made on behalf of people who lacked capacity to make those decisions for themselves.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective governance, including assurance and auditing systems or processes, to identify where improvements were needed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Not all staff had completed the programme of training to ensure that they knew how to support people safely.