Review of compliance

Homesend Limited Victoria Nursing Home	
Region:	North West
Location address:	9 Anson Road Victoria Park Manchester Greater Manchester M14 5BY
Type of service:	Care home service with nursing
Date of Publication:	November 2011
Overview of the service:	The home is situated in the Victoria Park area of Central Manchester close to local shops, public houses, Manchester Royal Infirmary and a range of social and leisure amenities. The home offers accommodation on three floors with all communal spaces being on the ground floor. The home is a large converted semi-detached building, adjoining Surrey

	Lodge Health Centre.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Victoria Nursing Home was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 28 September 2011, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

People who were able to express a view were generally positive about the care they received although some mixed views were expressed. People told us that generally the staff listened to their views and respected their need for privacy. One person said, 'It's great living here, the food and all that.' People were not aware of their care plans and one person told us, 'I would like a copy of one if there were things written about me.' Another person said, 'I'm not liked here but they take me to the doctors if I am not well. The staff don't really talk to me.'

One person told us there were not enough activities and they did get bored. Another person told us they had enjoyed a trip out to Blackpool the previous day.

People were seen to receive support from other health professionals and people told us they received support to have their physical needs met.

What we found about the standards we reviewed and how well Victoria Nursing Home was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People do not always have the opportunity to be involved in their own care planning and don't always have the opportunity to say what is important to them. There were some gaps in promoting the dignity of people who lived at Victoria.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

People are at risk of not receiving the care they need because their needs are not properly assessed and planned for.

Outcome 07: People should be protected from abuse and staff should respect their human rights

People were not effectively protected from poor care and treatment. Recent allegations highlighted gaps in the home's arrangements to ensure people are protected from abuse.

Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare

People who used the service lived in surroundings that had some risks to their safety and were not always well maintained.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

People did not have their needs met by well informed, competent staff. We found that some staff had not received appropriate levels of training and development.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

People who use the service were put at risk by ineffective management, assessment and quality monitoring systems.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

There are moderate concerns with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
People using the service at Victoria Nursing Home told us that they felt staff listened to them. One person told us that staff respected their need for privacy. Another person told us that weeks ago they had asked for the priest to visit but she had not heard anything. The manager was not aware of this request but did agree to support this person to attend church.
Comments made from people included;
' I didn't know I had a care plan, I thought my community worker held this about me. I would like to see it if it was possible.'
They also told us that they were able to have some influence on life in the home.
"I like it here. The staff are kind to me. They knock on my door before they come in."
"I have no problem with how any of the staff treat me, they are really helpful."
" We have residents meetings each month with the staff where we talk about things in general and where we will go on our trips out."

Other evidence
During the visit we looked at four peoples care plans. There was no record to show how people were involved in these or to show they were reviewed on an ongoing basis with the involvement of the person. People we spoke to did not know they had a care plan in place.

We saw that staff spoke to people in a respectful way generally and staff were heard being gentle in their approach. There was some evidence that people were encouraged to care for themselves and independence was encouraged. Staff told us that they encouraged people to be involved in decisions about the care and support they received and about making choices. One person was seen to spend the day out of the home with the support of a staff member. Staff members were heard calling people by a number of terms of endearment or name shortenings which did not always sound appropriate.

Some shortfalls were seen for example staff were seen putting a plastic apron over a person before lunch and afterwards said to this person, 'Can I put this on for you whilst you have your lunch?' Staff should be reminded of the need to use each person's preferred term of address so that people who use the service feel their wishes are being respected at all times.

We observed that one person spoke a foreign language. There was no evidence in this persons care plan to show how this person was supported to communicate or whether information had been made available in their language. Staff confirmed they had close relationships with this person's family.

Peoples need for privacy was not fully respected. We noted there was no blind in place in the bathroom window on the first floor. We were told this had happened recently. One person told us, 'I do feel peculiar in the bathroom, its very light in there.'

From the care plans we looked at we did not see records to show that an independent mental capacity advocate had visited people who may have lacked the capacity to make decisions about their care. The manager told us this would be looked at.

People living at Victoria had been given opportunities to express their views and for information to be shared with them during meetings. Records were seen of meetings staff held with people which included details of issues and ideas people raised about daily life in the home. We discussed with the manager in relation to recording if action had been taken to address any of the issues raised. A nurse told us action was taken but this was not recorded.

Our judgement
People do not always have the opportunity to be involved in their own care planning and don't always have the opportunity to say what is important to them. There were some gaps in promoting the dignity of people who lived at Victoria.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are moderate concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We spoke to some people using the service who were satisfied with the health and personal care support they received.

One person told us, ' if I was physically poorly the staff would take me to see my GP next door.' One person told us that they would, 'watch the TV or read books in my room if I felt anxious, but recently I have not been able to do this.'
Another person told us 'It's great living here, the food and all of that. You can get up and go to bed when you like.' Another person told us, 'I have been here for about 18 months and feel I have improved. It feels like my home here.'

One person told us they got bored and there was not enough to do. Another person told us they went to the shop every day with the staff and had enjoyed the trip to Blackpool the day before.

Other evidence
We looked at the care records of four people. Care plans contained risk assessments and copies of an assessment of the person's needs. The care plans did not always include personalised information about people's individual abilities and needs and how the staff member should support them. We saw the care plans included the use of a hygiene record chart which recorded the support provided for peoples personal hygiene needs. These charts showed gaps in care delivery, for example one person's record showed they received a bath on the 10th September and not again until the 18th September 2011.The chart for monitoring the person's bowels showed they had been

only once in September 2011.

People using the service were able to access care and support from a variety of health and social care professionals including doctors, specialist nurses and social workers. We had some concerns in relation to the recording in the care plans, for example for one person, the information recorded in the wound care plan following the advice and support from the other professionals was not clearly recorded and included as part of this persons care plan. Information to show the ongoing monitoring of this wound, including an assessment was not clear.
We spoke to the manager who could explain the care provided but the information and instructions for staff to follow in the care plan were not clear.

We observed some people using the service who were not able to clealry communicate to us to be able to give us their view of the service they received. Some people were left unattended for an hour with little staff intervention. One person became quite distressed and was reaching out for support. This person was left unattended and the staff told us, 'it was difficult to know what is best for this person, they just sit there.' One person had returned from hospital on the day of this visit, they were in the lounge chair from 11.00am and were still there at 16.30pm. Staff supported this person with pillows in the afternoon when they fell asleep in the chair. For another person their clothes were damp from saliva and for a lengthy period of time no staff interacted with this person. Staff at one time moved a person's feet and did not explain to the person they were going to carry out this movement. Afterwards they said to each other, 'Let's put them like this.'

During our visit we saw limited evidence of any people's social or recreational needs being met. We did not observe staff supporting anyone with any activities. People were generally wandering around or watching television or sitting in the lounge. Staff told us there was a range of activities available and it was difficult some times to motivate people to join in planned activities. There was artwork displayed which people had carried out with support from the activities organiser. Records in care plans for activites carried out were not up to date.

Our judgement
People are at risk of not receiving the care they need because their needs are not properly assessed and planned for.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

There are major concerns with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
People who were able to express a view told us their needs were met and they told us the staff were generally kind and treated them well. One person told us, 'In the main staff are nice but one or two are very strict. I think they try their hardest.'

Other evidence
There were shortfalls in the recording and reporting of unsafe practice.For one person their care plan had last been reviewed on the 8.7.2011. Since that date there had been an incident reported to adult safeguarding by the staff. This person's care plan and risk assessment had not been updated to show this information. A further allegation had been made by this person which had not been reported to safeguarding. Safeguarding investigations had been started to have been looked into by the service themselves.

Care plans for one person showed techniques to use when people were showing challenging behaviour. There was not enough detail to show the exact techniques that may assist that person and no record to show these techniques were discussed with the individual.

We received some concerns by telephone from a person who chose to remain anonymous in relation to some poor care practices.
At the time of this visit some serious allegations were being investigated under adult safeguarding procedures. The provider was cooperating with Manchester City Council and external agencies as necessary.
Two staff spoken to were aware of what abuse was but were not clear how they would

report this if the allegation was about someone senior to themselves. The manager told us he felt he needed to re visit how allegations of abuse were managed in the service and to address issues as a staff team. The registered manager had not recently reported allegations of abuse in a timely manner to the appropriate authorities including the Care Quality Commission. We were told by the management that some staff had not recently attended training in adult protection. We were told the manager used an in house training package and we discussed the benefits of using some additional external training.

Our judgement
People were not effectively protected from poor care and treatment. Recent allegations highlighted gaps in the home's arrangements to ensure people are protected from abuse.

Outcome 10:
Safety and suitability of premises

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
* Are in safe, accessible surroundings that promote their wellbeing.

What we found

Our judgement

There are moderate concerns with Outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us
Some of the people using the
service were not able to communicate clearly enough to be able to give us their view of the premises. Some people told us they liked their bedrooms and they liked having their 'things' around them.

Other evidence
We had a partial tour of the premises including some people's bedrooms, bathrooms and toilets.
We found some areas were in need of some refurbishment and some areas that needed addressing as a matter of urgency. The window in the first floor bathroom had no window restrictors in place. The sash window could be opened fully and access gained to the flat roof outside. Tiles had become removed from around the shower, there was a missing spindle from the banister rail. We raised these concerns with the managers during this visit.

The outside grounds were in a poor state. There was moss on the path outside the front door where there has been a leak from the overflow pipe, this may potentially be a slip hazard for people. The garden was unkempt and parts were overgrown.
On the day of this visit some people did choose to sit outside on the garden furniture, we were told there are plans to develop this area to make the grounds more pleasant for people. The general manager told us the maintenance of the building was an ongoing project.

Our judgement

People who used the service lived in surroundings that had some risks to their safety and were not always well maintained.

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

There are major concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
People told us mixed messages. One person told us,'The staff are kind. If I was worried I would tell the owner and think she would do something to help me.' 'It's all right here the way it is.' Another person when asked if there was anything they would consider changing, the said, 'It's not for me to say. They wouldn't listen to what I have to say.'

Other evidence
We observed one of the lounges during the visit where a number of people spent their day. There were long periods of time where there were no staff to observe or attend to peoples' needs. We saw that staff were not always around to respond to people's needs or to give them some attention. It was clear that people's basic needs were met, people's finger nails were lengthy but clean.

We saw some poor moving and handling techniques. For one person who used the service they were balancing on the edge of a reclining chair. The care worker eventually put the chair in the reclining position which left the person lying with their head on the flat cushion of the chair. We suggested this care worker got some support from another staff member and the two staff then used an underarm technique to move this person up the chair. This care worker told us they had not received training in moving and handling.

From the observations we made and discussions with staff who told us they had not received training to support them to carry out their job properly. Although new staff told us they felt they were supported by the manager and senior staff, they said their induction lasted for one day when all policies and procedures were discussed. This

person had no previous experience of working in mental health nursing . Another person told us 'I know the word de escalation technique when someone has challenging behaviour but I do not know what I am meant to do and if I am honest it leaves me feeling quite scared or unsure at times.'

We spoke to the manager about clinical supervision. We were told that since the recent death of one the home owners he had not accessed clinical supervision. The manager had planned some training to update himself on the deprivation of liberty safeguards. Staff told us they were supervised by a senior staff member on a regular basis but their training needs had not been addressed.

The general manager told us they had requested one of the mental health support workers to provide some in house training.

Our judgement
People did not have their needs met by well informed, competent staff. We found that some staff had not received appropriate levels of training and development.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

There are major concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
People using the service at Victoria Nursing Home told us they were asked their views about how they were cared for and said they do attend residents meetings.

Other evidence
We looked at a file of incident reports for a number of people. These did not always include details of how they had been looked into and what the outcome for people was. There was no system in place to monitor the incidents for themes and trends. It was not clear how any incidents were learned from and how or if this information was shared amongst the staff team.

There was no formal structure in place to monitor the quality of care. There had been a service user survey but this was last completed in May 2010. During this visit we saw that personal hygiene charts were not well completed and the manager could not provide us with examples of audits carried out to monitor the standards in the home. The manager told us the service and staff were all missing the guidance and support from the recently deceased home owner/general manager.

We had received some 'Statutory Notifications' from the provider which are the reportable important events that affect people who use the service. However there are some reportable events/incidents the provider has not told us about (see outcome 7).

In some of the care files we looked at during this visit, actions to support people were not always clear and did not give staff accurate or appropriate guidance on how to

support people. Risks were not always clearly identified or safety measures were not always in place to minimise the risk.

Our judgement
People who use the service were put at risk by ineffective management, assessment and quality monitoring systems.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: People do not always have the opportunity to be involved in their own care planning and don't always have the opportunity to say what is important to them. There were some gaps in promoting the dignity of people who lived at Victoria.	
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: People do not always have the opportunity to be involved in their own care planning and don't always have the opportunity to say what is important to them. There were some gaps in promoting the dignity of people who lived at Victoria.	
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People are at risk of not receiving the care they need because their needs are not properly assessed and planned for.	

Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People are at risk of not receiving the care they need because their needs are not properly assessed and planned for.	
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: People were not effectively protected from poor care and treatment. Recent allegations highlighted gaps in the home's arrangements to ensure people are protected from abuse.	
Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: People were not effectively protected from poor care and treatment. Recent allegations highlighted gaps in the home's arrangements to ensure people are protected from abuse.	
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	How the regulation is not being met: People who used the service lived in surroundings that had some risks to their safety and were not always well maintained.	
Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises

	How the regulation is not being met: People who used the service lived in surroundings that had some risks to their safety and were not always well maintained.	
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: People did not have their needs met by well informed, competent staff. We found that some staff had not received appropriate levels of training and development.	
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: People did not have their needs met by well informed, competent staff. We found that some staff had not received appropriate levels of training and development.	
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: People who use the service were put at risk by ineffective management, assessment and quality monitoring systems.	
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: People who use the service were put at risk by ineffective management, assessment and quality monitoring systems.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health 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 Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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