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:	June 2012
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 semidetached building.

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. Action is 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:

Outcome 04 - Care and welfare of people who use services
Outcome 07 - Safeguarding people who use services from abuse
Outcome 10 - Safety and suitability of premises
Outcome 11 - Safety, availability and suitability of equipment
Outcome 12 - Requirements relating to workers
Outcome 13 - Staffing
Outcome 14 - Supporting staff
Outcome 16 - Assessing and monitoring the quality of service provision
Outcome 21 - Records
Outcome 22 - Requirements where the service provider is an individual or partnership

How we carried out this review

We reviewed all the information we hold about this provider.

What people told us

We found that people at Victoria nursing home enjoyed living there. People said staff were good and that they had the freedom to come and go as they liked. We saw that staff and people living at the service got on well. People living at Victoria nursing home were supported to access the local community and participate in outings within the local area and further afield. The home was clean and provided comfortable accommodation.

Comments included:

"I get on well with the staff."

"The food's not bad."

"I think of this as family."

We completed this compliance review in response to concerns raised by our partner agencies including Manchester City Council and the Greater Manchester Police Authority

about care provided in the home.

We found that the day to day care and support was effective in promoting the wellbeing and safety for most people living at the home, most of the time.

We found that the registered provider and manager did not always respond appropriately to safeguarding concerns when they were raised.

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

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

The provider was meeting this standard. People were provided with safe and effective health care that was in line with their individual assessed needs; however more stringent supervision would ensure that all staff carry out tasks in a more thoughtful manner.

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

The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard. People who used the service were not fully protected from effects of abuse or exploitation within the home.

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

People who use the service, staff, and visitors were protected against the risks of unsafe or unsuitable surroundings.

Outcome 11: People should be safe from harm from unsafe or unsuitable equipment

The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard. People working at Victoria nursing home did not provide sufficient evidence that up-to-date training in moving and handling was provided however equipment was properly maintained.

Outcome 12: People should be cared for by staff who are properly qualified and able to do their job

The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard. People living in Victoria nursing home were supported by staff that had been recruited through robust procedures. However additional steps were needed to ensure that the management team followed up new information available about established staff, and that every one working in the home could be accurately identified.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

The provider was meeting this standard. People who used the service had their needs met by sufficient numbers of staff.

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

The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard. People who used the service are cared for by staff who were supervised and received training but there were gaps in their mandatory training.

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

The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard. Auditing and monitoring tools in relation to the homes regulated activities were not fully developed.

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard. People's personal information was readily available however there were gaps in the way some information was managed.

Outcome 22: Services must be provided by people who are honest, reliable and trustworthy. They must also have the right skills, experience and qualifications to do the job

The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard. The registered person at Victoria nursing home did not understand fully how to identify, respond to, and deal with all safeguarding issues concerning people at Victoria nursing home, and so did not always promote adult protection as much as possible.

Actions we have asked the service to take

We have asked the provider to send us a report within 7 days of them receiving this report, setting out the action they will take. We will check to make sure that this action has been taken.

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.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that 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.

A moderate impact means that 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.

A major impact means that 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.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

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

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

The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
People who lived at Victoria nursing home felt their care and welfare needs were met and that they were treated well.
We were told:
"I've not been to hospital for a good while and I think that being here has kept me out of hospital."
And
"I always tell the staff where I'm going."

Other evidence
We visited Victoria nursing home and observed the condition of the people who lived there. We saw that the people were supported to a good level of personal hygiene and were well dressed.

We saw that people at Victoria nursing home were supported to maintain their independence and were protected from sensory deprivation; this was because staff ensured that aids such as eye-glasses were clean and worn correctly.

We looked in detail at the health and social care for six people, (we call this pathway tracking). We did this to assess how people's health and social care needs were being met at Victoria nursing home.

We saw that people living at Victoria nursing home had their health and social needs assessed and a care plan was developed from information gathered. Care plans

addressed people's care needs and were individualised and person centred. Specialist risk assessments such as nutritional needs, skin care and initial moving and handling needs were in place for people and ran alongside care planning documentation.

We found that people's needs were reviewed and plans of care updated on a regular basis. We saw from the way in which the care plans were written that the people were involved in planning their care and support. Two of the care plans we reviewed included detailed comments and directions of preferred care by the people concerned. We told the registered provider that this was good practice and recommended that this be developed for other people who use the service.

We read daily reports and other records made by staff about people living at the service. We found that daily records were detailed and provided information on how a person's care needs were being met, personal changes, and details of visiting professionals.

We saw that medical attention was appropriately sought and that people received treatment when they were ill. It was also clear from the presence of prescriptions and other letters that routine screening and health-checks such as eye tests and hearing tests had been completed.

The service used a health monitoring form on which people's weight, blood pressure, temperature, and heart rate were recorded. We saw that health monitoring forms were not always completed in full. For example the blood pressure readings, temperature, and heart rate were not always recorded on a monthly basis as requested. We acknowledged that this may not always be necessary; however the manager understood that if these were not completed then an explanation for the omission should be documented.

We saw that activities offered were person centred. We felt that the atmosphere in the home was relaxed. People were watching television or talking to staff. We observed that there was appropriate and good rapport with staff. We observed one nurse having a game of dominos with a service user while others watched and commented on the game.

We observed positive interaction between care staff and people living at the service but were concerned to see a member of staff putting an apron on a person without asking their permission or talking to them. We saw that this person was startled when unexpectedly approached by the staff member. This behaviour had been previously noted during an inspection visit in January 2012 and was discussed with the registered provider. We were concerned to see that this practice was still occurring and asked the registered provider to ensure that care staff received effective supervision.

Our judgement
The provider was meeting this standard. People were provided with safe and effective health care that was in line with their individual assessed needs; however more stringent supervision would ensure that all staff carry out tasks in a more thoughtful manner.

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

The provider is non-compliant with Outcome 07: Safeguarding people who use services from abuse. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
People who commented said they liked the staff.

Other evidence
We looked at the records held by the home concerning safeguarding and incidents sent to the Care Quality Commission. We talked with staff working at Victoria nursing home about their knowledge and understanding about recognising and reporting safeguarding concerns. We checked staff training records to find out whether safeguarding training had been provided. We discussed safeguarding issues with the registered manager and registered provider. We read through the notifications and other correspondence about safeguarding matters sent to us by the home.

The training matrix which is a record kept by the service about training showed that 23 out of 28 staff had completed protection of vulnerable adults since 01 December 2011 which meant that all staff had completed safeguarding adult training since 2010. The qualified nurses were now due for an update of this course.

We saw certificates confirming that Manchester city council training unit had provided this training. This demonstrated that all staff had received information about how to protect vulnerable adults and what to do if they had concerns.

We talked to staff working at Victoria nursing home and we found that they knew the correct actions to take in relation to safeguarding vulnerable adults. We also found from

information in records and files that staff had taken action and complained about the behaviour and conduct of their colleagues if there was cause for concern. This showed that staff were diligent and took steps to protect people from harm.

We were concerned to find that safeguarding issues brought to the attention of the registered manager and provider were not always shared with the Manchester city council safeguarding team and they failed to notify CQC under the Health and Social Care Act 2008. This meant that the home was not following the local safeguarding policy as expected. This meant that the local authority were not always given the opportunity to carry out their statutory duty of dealing with safeguarding vulnerable adults concerns and protecting vulnerable adults from harm.

We found that the management team were uncertain about what needed to be treated as safeguarding and why, for example the records at Victoria nursing home showed that at times incidents reported to Manchester contact centre as possible safeguarding were reported to the Care Quality Commission (CQC) as notifications or went unreported. This meant that CQC did not have accurate information about the number and type of safeguarding incidents in the home to assist with our information gathering process.

The way in which the service responded to safeguarding issues had a moderate impact on people who use the services and put people at risk of harm.

We were disappointed to see that the management team were unable to sustain the improvements in dealing with safeguarding that were identified at the previous CQC compliance visit in January 2012.

Our judgement
The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard. People who used the service were not fully protected from effects of abuse or exploitation within the home.

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

The provider is compliant with Outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us
People we talked with did not make any negative comments about their surroundings.

Other evidence
The provider was meeting this standard. We saw that there were adequate communal areas for people and they had a choice of where to sit. There was a quite room available for those who liked a bit of peace and quite. Furniture and fixtures and fitting were clean and modern.

We saw that some parts of the home had been refurbished with new flooring and there were plans to remove carpet on the top floor which was worn and stained.

We saw that some people had personalised their bedrooms and their bedding and curtains were clean. Some bedroom doors had a coded keypad locks and people knew the codes to access their room.

We were informed that there was an ongoing maintenance and refurbishment programme and that there were plans to replace hospital beds and older bedroom furniture.

Our judgement
People who use the service, staff, and visitors were protected against the risks of unsafe or unsuitable surroundings.

Outcome 11:
Safety, availability and suitability of equipment

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
* Are not at risk of harm from unsafe or unsuitable equipment (medical and non-medical equipment, furnishings or fittings).
* Benefit from equipment that is comfortable and meets their needs.

What we found

Our judgement

The provider is non-compliant with Outcome 11: Safety, availability and suitability of equipment. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
People we talked with did not raise any concerns about the equipment at Victoria nursing home.

Other evidence
We discussed the maintenance of equipment and services in the home such as gas, electricity, and emergency equipment. We saw a report dated 6 September 2011 confirming that the gas boiler had been serviced and maintained by a certified gas engineer.

We saw evidence that the lift was regularly serviced most recently in April 2012. Portable appliance testing checks on small electrical appliances were up to date and water safety checks had been completed on the 5 May 2012.

We saw stickers on hoists confirming that they too had been serviced.

The training matrix showed that eight staff out of twenty seven had received moving and handling training since 2010. This meant that staff had not received yearly moving and handling updates as required.

During the compliance review we were provided with additional information concerning moving and handling training. This was a tick list indicating that 14 staff had been

assessed as competent in moving and handling. This evidence was not robust enough to confirm that staff were trained because there were no dates for when each assessment was conducted, and neither had the assessor or assessed member of staff signed to confirm that an assessment had been carried out.

We saw certificated evidence that a member of staff had completed the specialist 'Train the Trainer' moving and handling course in January 2012. This course covered practical moving and handling, moving and handling risk assessments and teaching skills. This meant that the service had a member of staff that could be instructed to bring moving and handling training up to date, but strong evidence that this had been achieved was not provided. Therefore we could not be certain that staff in the home had adequate moving and handling skills.

Our judgement
The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard. People working at Victoria nursing home did not provide sufficient evidence that up-to-date training in moving and handling was provided however equipment was properly maintained.

Outcome 12:
Requirements relating to workers

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 staff who are fit, appropriately qualified and are physically and mentally able to do their job.

What we found

Our judgement

The provider is non-compliant with Outcome 12: Requirements relating to workers. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
People receiving a service from Victoria nursing home told us that they liked the staff.

Other evidence
We visited Victoria nursing home and looked at staff recruitment records. We looked at the records for two care staff and one trained nurse. A copy of the persons application form remained on file. The files also contained copies of references and proof of identity such as utility bills. We saw that Criminal Record Bureau (CRB) checks were completed. This showed that staff had been recruited following a thorough vetting process.

We discussed the management of possible disclosures on CRB's.

The management team did not follow up the outcomes of issues identified as unresolved on CRB's, this could put people at risk of been supported by unsuitable or inadequately supervised staff.

We saw that a system was in place to supervise and assess the capability of new recruits. We saw that detailed appraisals were recorded and included how the person felt they had settled into the role of carer, observations made by the supervisor and information from others working alongside the new member of staff. Their file also contained a progress log with details of the common induction course they had completed at Victoria nursing home.

This showed that new recruits were given the time to get to know the running of the home and the people living there so that they knew what to do meet peoples needs safely and effectively.

We discussed staff disciplinary procedures with the registered provider. We were informed that the process of dismissal for gross misconduct concerning the treatment of vulnerable adults included referral of the person to the Independent Safeguarding Authority. This means that potential employers would be made aware that there had been a serious incident concerning the persons' conduct in relation to vulnerable adults.

We talked to two agency staff. One had photo identification but the other did not. We discussed with the manager the need for agency staff to provide verification of their identity as a means of ensuring they had been vetted and were who they said they were.

Our judgement
The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard. People living in Victoria nursing home were supported by staff that had been recruited through robust procedures. However additional steps were needed to ensure that the management team followed up new information available about established staff, and that every one working in the home could be accurately identified.

Outcome 13:
Staffing

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 sufficient numbers of appropriate staff.

What we found

Our judgement

The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
People we talked with did not voice any concerns about the number of staff or their ability to do their jobs. The home had a lot of new agency staff working at the service and some people told us that they didn't like this, they referred to these staff members as 'strangers' and said they wanted things to settle down.

Other evidence
On the day of the inspection visit there were 15 people using the service as one person was in hospital. Staff on duty during the day of the visit included the registered provider, registered manager, two registered mental health nurses, five care assistants, and kitchen and laundry staff. In the late afternoon and evening there are three care assistants and a qualified member of staff. We were told the night duty was to be covered by two registered mental health nurses and two care assistants. This staffing level was considered to be ample by the staff and people using the service who talked to us.

We discussed the male to female ratio of staff with the registered manager and registered provider. We did this because there were nights when two men and one female were on duty. This meant that if a female went off duty and a replacement could not be found then an all male staff team were left to provide personal care to the men and women living at Victoria nursing home. We had been informed that this had happened at the home on one occasion. The manager confirmed that this had been brought to his attention. The manager and registered provider said this was due to exceptional circumstances but decided that in the future when there were two men

working on the night shift, in order to reduce the risk of an all male staff team, two women would also be rostered to work.

Staff we talked with said they did not feel the home was ever understaffed. We were told that the manager and provider listened and responded when it appeared that staffing needed to be reorganised, for example, the manager and provider had changed the shift pattern in the home so that extra staff were available during the day when people wanted to go out and needed extra one to one attention.

We observed the interaction between care staff and the people living at Victoria nursing home. We saw that staff were able to sit with people on a one to one or small group basis. We saw that people went out with staff on a one to one basis. This demonstrated that at the time of the inspection visit sufficient staff were on duty.

Our judgement
The provider was meeting this standard. People who used the service had their needs met by sufficient numbers of staff.

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

The provider is non-compliant with Outcome 14: Supporting staff. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
People we talked with were confident that the staff at Victoria nursing home were knowledgeable about how to meet their needs.

Other evidence
We looked at the training matrix given to us by the registered provider.

We saw mixed information concerning the standard of training in that we found that some mandatory training such as health and safety and infection control were not routinely updated. This meant that staff might not always have the latest information in respect these topics.

We also saw that since 2010 the majority of staff had completed food hygiene training, this meant that the training was current as this needs to be updated every two or three years depending on the level of the course.

We saw that out of 20 care assistant staff employed 15 had completed a National Vocational Qualification (NVQ) in health and social care at level 2 or 3. Most staff had attained this while working at Victoria nursing home. This showed that care staff had been supported by the manager and provider to achieve a recognised qualification to enable them to do their jobs well.

We looked at the supervision records for 12 members of staff. The records confirmed that staff received supervision approximately every six weeks. We saw that the carers' performance was scored out of 10. Topics discussed at supervision included, record

keeping and communication, safeguarding, ideas about improving the service, the wellbeing of the service users, the homes policies and procedures and behaviour and attitude of the individual staff. Other topics included staff development, duty of care, and dealing with aggression.

We were also provided with a resume of staff meeting and supervision discussions developed by the registered provider. This showed that the manager and provider kept an overview of the topics discussed so that they could recognise gaps in the information given to staff and plan supervision topics accordingly.

We talked to four members of staff. One nurse and one care assistant from an agency and one nurse and one care assistant who worked at the home permanently.

Members of staff said they enjoyed their jobs.
Comments from staff included:
"Everyone here is very approachable. It's difficult when your under scrutiny but all the staff are really, really nice. Staff really know the patients well."

"The trained nurse teaches us about mental illness and the effects it has on people and what to do to reduce the effect."

"I had a two week induction with a supervisor."

Our judgement
The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard. People who used the service are cared for by staff who were supervised and received training but there were gaps in their mandatory training.

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

The provider is non-compliant with Outcome 16: Assessing and monitoring the quality of service provision. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
People we talked with felt they were able to comment and influence what happened at Victoria nursing home.

Other evidence
We discussed quality monitoring with the manager and provider in relation to the systems in use to monitor the running of the home. We wanted to look at audits and evaluations of record keeping such as care plans; audits of incidents, accidents and safeguarding; staff absence analysis and medication audits. We wanted to see how the provider assured themselves that the home was running to the standard they expected.

We were informed that that an audit plan was under development. We looked at a form that was going to be completed. The form had columns entitled care plans, medication, cleaning, data protection, signing in, kitchen hygiene, training schedule, petty cash, and laundry. We recommended that the registered manager and provider put this audit plan to further use.

We saw that an audit tool for care plans had been introduced and two had been completed.

We saw that the registered provider was in the process of analysing accidents, incidents, and safeguarding events. However we could not be confident that the final analysis would be an accurate picture of what was happening at Victoria nursing home.

This was because the safeguarding and incident reporting procedure was not used in a consistent way.

The manager and registered provider confirmed that staff meetings took place. We read through the latest record to check whether the quality of the service was discussed.

We read the staff meeting records dated 14 May 2012. We saw that the standard of record keeping was discussed. This showed that although the audit tool was not fully developed the manager was making checks on some of the tasks completed by staff, and giving advice about the improvements needed.

Our judgement
The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard. Auditing and monitoring tools in relation to the homes regulated activities were not fully developed.

Outcome 21:
Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:
* Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
* Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

The provider is non-compliant with Outcome 21: Records. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
People we talked with did not comment on the management of their records, however, people were aware that information about their care was kept.

Other evidence
We visited the home and looked at records concerned with the care of people living at Victoria nursing home and the staff working in the home.

We saw that accurate information was available for each person we pathway tracked. We saw that this information included documents in relation to the care and treatment provided.

We saw that historical records were kept for people who lived at the home. This meant that it was possible to track people's progress and treatment throughout their stay at Victoria nursing home.

We saw that the appropriate records were available for the people employed by the home.

We saw that files were kept securely and could be located promptly.

We saw from the quality audit tool that the registered manager and provider were

planning to audit record keeping in the home.

We saw some gaps in records because some forms had not been completely filled in. This meant that records did not always provide the information expected.

We also found that information about different people was written on the same pages of record books. This meant that confidentiality would be compromised whenever information for only one person was required. This also made storing the information in individual and confidential files difficult to achieve.

Our judgement
The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard. People's personal information was readily available however there were gaps in the way some information was managed.

Outcome 22:
Requirements where the service provider is an individual or partnership

What the outcome says

This is what people who use services should expect.

People who use services:
* Have their needs met by the service because it is provided by an appropriate person.

What we found

Our judgement

The provider is non-compliant with Outcome 22: Requirements where the service provider is an individual or partnership. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
People who used the service told us that they liked the registered provider. It was clear from what people said that they found the provider approachable and able to act on what she was told.

Other evidence
We spent time with the registered provider. We found that provider assisted us with the inspection process.

During the time of the review we were also in conversation with our partner agencies, Greater Manchester Police Authority, Manchester NHS and Manchester city council because of concerns raised about the management of the home.

We found that the provider cooperated effectively with the CQC review process.

We found, however, that at times each agency said they were given different information by the provider about the actions taken in response to requests made over the period of this compliance review.. We found that the provider did not inform us when a task agreed on could not be undertaken. This gave a sense of unreliability. We discussed this matter with the registered provider who explained that legal guidance had further influenced decisions made in relation to the requests made by our partner agencies and the information provided to us. The provider felt that the priority was to take action in relation to promoting the wellbeing of people living and working at Victoria

nursing home and that this had been achieved.

We discussed the day to day management needs of Victoria nursing home with the registered provider. The registered provider acknowledged that there was a lot to do in order to pull all the audit systems into line.

The provider felt that since the middle of 2011 Victoria nursing home had not experienced a period of stability to allow for quality assurance systems to be updated, used, and embedded.

We discussed our particular concern about the way in which incidents and injuries to people living at Victoria nursing home were managed in respect of informing statutory services and action taken to prevent recurrence of the same or similar events.

Although we were informed that there was a better understanding of what needed to be referred to safeguarding, we found during our visit, serious and significant events that had recently occurred which the provider had over looked in respect of informing safeguarding or sending in a Care Quality Commission notification.

We updated Manchester adult safeguarding in relation to some of the information we found during the compliance visit on 15 May 2012.

We found that the provider was not always effective at dealing with matters of concern raised. For example we were present on 30 April 2012 when our partner agencies had advised the registered provider to ensure that all agency staff carried identification badges, and the registered provider agreed to make this happen. At our visit on 15 May 2012 we saw that only one of the agency staff owned an identification badge. Discussion with the provider showed that no effective action had been taken to make sure that agencies only sent staff with suitable identification. This meant that we could not be confident that the provider would follow through, in a timely manner, plans that were agreed.

We found that the provider was keen to maintain control and steer improvements in the home. The provider informed us that she and an Registered Mental Health Nurse had commenced the National Vocational Qualification (NVQ) Level 5 in Leadership and Management of Care in January 2012. The provider was approximately one-third through the course. The provider felt that this course would provide her with the skills to develop robust quality assurance systems at the home.

The registered provider said they would consider employing a management consultant to assist with developing effective management processes that would underpin the work of the registered nurses and care staff in providing effective and safe support.

Our judgement
The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard. The registered person at Victoria nursing home did not understand fully how to identify, respond to, and deal with all safeguarding issues concerning people at Victoria nursing home, and so did not always promote adult protection as much as possible.

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 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: People who used the service were not fully protected from effects of abuse or exploitation within the home.	
Diagnostic and screening procedures	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 who used the service were not fully protected from effects of abuse or exploitation within the home.	
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 who used the service were not fully protected from effects of abuse or exploitation within the home.	
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA 2008 (Regulated Activities)	Outcome 11: Safety, availability and suitability of equipment

	Regulations 2010	
	How the regulation is not being met: People working at Victoria nursing home were not provided with up-to-date training in moving and handling.	
Diagnostic and screening procedures	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 11: Safety, availability and suitability of equipment
	How the regulation is not being met: People working at Victoria nursing home were not provided with up-to-date training in moving and handling.	
Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 11: Safety, availability and suitability of equipment
	How the regulation is not being met: People working at Victoria nursing home were not provided with up-to-date training in moving and handling.	
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 12: Requirements relating to workers
	How the regulation is not being met: People living in Victoria nursing home were supported by staff that had been properly recruited. However additional steps were needed to ensure that every one working in the home could be accurately identified.	
Diagnostic and screening procedures	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 12: Requirements relating to workers
	How the regulation is not being met: People living in Victoria nursing home were supported by staff that had been properly	

	recruited. However additional steps were needed to ensure that every one working in the home could be accurately identified.	
Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 12: Requirements relating to workers
	How the regulation is not being met: People living in Victoria nursing home were supported by staff that had been properly recruited. However additional steps were needed to ensure that every one working in the home could be accurately identified.	
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 who used the service are cared for by staff who received training and supervision, but some training was not up to date.	
Diagnostic and screening procedures	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: People who used the service are cared for by staff who received training and supervision, but some training was not up to date.	
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 who used the service are cared for by staff who received training and supervision, but some training was not up to date.	
Accommodation for persons who require nursing or personal care	Regulation 10	Outcome 16: Assessing

	HSCA 2008 (Regulated Activities) Regulations 2010	and monitoring the quality of service provision
	How the regulation is not being met: Auditing and monitoring tools in relation to the homes regulated activities were undeveloped. This meant that when systems were not working the registered manager and provider did not know and so did not take action to prevent a repeat of the situation or improve outcomes for people.	
Diagnostic and screening procedures	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: Auditing and monitoring tools in relation to the homes regulated activities were undeveloped. This meant that when systems were not working the registered manager and provider did not know and so did not take action to prevent a repeat of the situation or improve outcomes for people.	
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: Auditing and monitoring tools in relation to the homes regulated activities were undeveloped. This meant that when systems were not working the registered manager and provider did not know and so did not take action to prevent a repeat of the situation or improve outcomes for people.	
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met:	

	People's personal information was readily available however there were gaps in the way some information was managed.	
Diagnostic and screening procedures	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: People's personal information was readily available however there were gaps in the way some information was managed.	
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: People's personal information was readily available however there were gaps in the way some information was managed.	
Accommodation for persons who require nursing or personal care	Regulation 4 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 22: Requirements where the service provider is an individual or partnership
	How the regulation is not being met: The registered person at Victoria nursing home did not understand fully how to identify, respond to, and deal with all safeguarding issues concerning people at Victoria nursing home, and so did not always promote adult protection as much as possible.	
Diagnostic and screening procedures	Regulation 4 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 22: Requirements where the service provider is an individual or partnership
	How the regulation is not being met: The registered person at Victoria nursing home did not understand fully how to identify, respond to, and deal with all safeguarding issues concerning people at Victoria nursing	

	home, and so did not always promote adult protection as much as possible.	
Treatment of disease, disorder or injury	Regulation 4 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 22: Requirements where the service provider is an individual or partnership
	How the regulation is not being met: The registered person at Victoria nursing home did not understand fully how to identify, respond to, and deal with all safeguarding issues concerning people at Victoria nursing home, and so did not always promote adult protection as much as possible.	

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 7 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.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. 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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