Review of compliance

HC-One Limited Victoria Mews	
Region:	West Midlands
Location address:	487-493 Binley Road Coventry West Midlands CV3 2DF
Type of service:	Care home service without nursing
Date of Publication:	February 2012
Overview of the service:	Victoria Mews is registered to provide accomodation and personal care for a maximum of 30 people. The service provides for older people with dementia care needs.

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

Our current overall judgement

Victoria Mews was meeting all the essential standards of quality and safety.

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 to check whether Victoria Mews had made improvements in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 07 - Safeguarding people who use services from abuse
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 5 January 2012, checked the provider's records, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

We made an unannounced visit to this care home on 5 January 2012. This was our first review of this service since it was registered with a new provider in October 2011.

The registered manager of this service has been absent for several months. The provider has made alternative arrangements for the management of the home and a relief manager has been running the home since October 2011.

There were 25 people using the service when we visited. We met with 14 of these people.

People using the service at Victoria Mews have dementia care needs, which meant they might have difficulty engaging in complex conversations with us.

We spent time in two lounge areas closely observing people's experience. We looked at their mood, how they spent their time and how staff interacted with them.

We looked at three people's care records and spoke with the manager, the administrator and four care staff. We looked at some records relating to the running of the home.

We saw that people were not left unattended for extended lengths of times. There was a

staff presence in communal areas. We saw staff sitting and chatting with people when they were not involved in a task to meet a particular care need. People appeared to be comfortable in approaching staff with their requests and staff responded quickly.

We observed that staff treated people respectfully. People were addressed by their preferred names and staff were discreet when asking about care needs. Staff gave sensitive explanations when they were helping people, speaking to them at a pace and level appropriate to their individual needs.

We found that, overall, the service was meeting the care and welfare needs of people using the service.

There are systems in place to respond to suspicion or allegations of abuse to make sure people using the service are protected from harm.

We found evidence that showed people's health and safety are promoted because systems are in place to monitor the quality of the service provided.

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

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

People using the service receive the care and support required to meet their needs.

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

There are systems in place to respond to suspicion or allegations of abuse to make sure people using the service are protected from harm.

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's health and safety are promoted because systems are in place to monitor the quality of the service provided.

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 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 using the service at Victoria Mews have dementia care needs, which meant they might have difficulty engaging in complex conversations with us.

We spent time in one lounge closely observing people's experience. We looked at their mood, how they spent their time and how staff interacted with them.

We observed that people looked clean and appropriately dressed for the time of year.

We saw that staff were knowledgeable people's needs and their likes and dislikes and were kind, caring and attentive towards them.

We observed several interventions when staff used equipment such as a hoist to assist people to move safely. Staff explained what they were doing and gave sensitive assistance at a pace appropriate for each person.

We observed staff sitting with people during a meal time. Staff prompted some people to support them to eat their meal independently and gave sensitive assistance to people who needed to be fed.

We saw staff supporting people to make a choice of meal by holding plated meals in front of them and asking which they would prefer.

We observed several incidents when staff responded quickly and sensitively to people

who became agitated or distressed. We saw that staff acknowledged how people were feeling and were aware of strategies to alleviate anxiety

We observed appropriate procedures when staff gave people their medication. Staff spoken to told us senior care staff are responsible for this. Staff receive training and their competency is checked before they are permitted to administer medicines.

Other evidence
We looked at the care records of three people using the service.

Care records each contained a pre admission assessment of the person's needs and abilities. These assessments were used to develop care plans and record people's personal preferences for their everyday life which they might not be able to communicate because of their dementia needs.

For example, staff identified that one person required a soft diet to maintain their nutrition because they preferred not to wear their dentures. Monthly weight monitoring records showed the person was maintaining their weight.

Each person had a care plan, daily records and monitoring records.

Care plans were available for most of the identified needs of each person and supplied staff with the information required to make sure the person's needs were met appropriately. For example, we saw a care plan for a person identified as having a high risk of developing pressure sores. The actions included the use of a pressure relieving mattress, which we saw in use.

We saw evidence of the use of risk assessment tools for falls, nutrition, mobility and pressure sores. Where the outcome of the assessment identified an increased risk there was evidence of action implemented to minimise the risk. For example, one person was identified as having a high risk of poor nutrition. We saw a care plan in place to support their nutritional intake and monitor their weight. Records show that people have their weight monitored regularly.

Records in care files demonstrate they are supported to access other health care professionals such as GP, optician, dietician, speech and language therapy and chiropodist. There was evidence in people's care records that staff are observant of changes in people's health and make appropriate referrals to other health professionals.

Our judgement
People using the service receive the care and support required to meet their needs.

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 compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
People using the service at Victoria Mews have dementia care needs, which meant they might have difficulty engaging in complex conversations with us.

We observed that people were treated respectfully. When we asked, "Do you feel safe here?" people using the service responded positively. No one expressed any concerns about their safety.

We saw 'body maps' in people's care records which demonstrated that staff observe and record any injury such as bruising or skin laceration.

We observed that people felt confident in approaching the staff and asking for support.

Other evidence
The service had a policy and procedure for responding to safeguarding concerns and any allegations of abuse.
Staff training records showed that most staff had completed training on the safeguarding of vulnerable people in August 2011.

We spoke with three care staff who were able to describe signs and symptoms of abuse. Staff said they would report any observations of potential abuse to the manager and felt confident their concerns would be acted upon. Staff had an awareness of whistleblowing and the agencies they could report concerns to.

The manager was aware of her role and responsibilities in responding to suspicion and allegation of abuse. She has worked co-operatively with the local authority and other agencies during investigations.

We saw evidence of objective investigations into adverse incidents affecting people who use the service.

Our judgement
There are systems in place to respond to suspicion or allegations of abuse to make sure people using the service are protected from harm.

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 compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
We observed that people using the service felt confident in approaching staff to make requests or enquire about the daily routine, such as, 'What time is dinner?'

Staff told us they had noticed an improvement in the way the home is managed since the new provider and relief manager took over. They said the daily routine had been reviewed and changed so that staff could spend more time with people using the service. This meant people were less anxious and distressed.

Staff told us the use of communal areas had been reviewed and changed so that an activities room was located in the middle of the care home with resources easily accessible to people using the service with the support of staff.

Staff felt the overall atmosphere in the home felt 'calmer'.

Other evidence
The registered manager of this service has been absent for several months. The provider has made alternative arrangements for the management of the home and a relief manager has been running the home since October 2011.

Satisfaction surveys are distributed monthly to people who use the service and their families. The results are collated and analysed and used to develop improvement plans, where necessary.

Monthly audits of working practices are carried out to measure how the home is performing. We looked at the home's quality assurance file, which demonstrated that action plans are developed to make improvements where they are identified as needed. We also saw evidence of review against the original objectives set, to check if improvements were achieved. For example, we saw that the processes for developing care plans and maintaining care records has been reviewed. People's care records were current and there is evidence of ongoing review.

The manager was organised, methodical and knowledgeable about the Essential Standards. On the day of our visit she was able to produce all the documentation she had collated to demonstrate compliance.

Our judgement
People's health and safety are promoted because systems are in place to monitor the quality of the service provided.

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

Document purpose	Review of compliance report
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