

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

## Victoria Mews

487-493 Binley Road, Binley, Coventry, CV3 2DP

Tel: 02476651818

Date of Inspection: 26 September 2013

Date of Publication: October 2013

We inspected the following standards as part of a routine inspection. This is what we found:

<b>Consent to care and treatment</b>	✓ Met this standard
<b>Care and welfare of people who use services</b>	✗ Action needed
<b>Safeguarding people who use services from abuse</b>	✓ Met this standard
<b>Staffing</b>	✓ Met this standard
<b>Complaints</b>	✓ Met this standard

## Details about this location

Registered Provider	HC-One Limited
Registered Manager	Mrs. Jean Sybil Rogers
Overview of the service	Victoria Mews is registered to provide accommodation for up to 30 older people who require personal care. This care home provides a service for people with dementia care needs.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

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

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## Summary of this inspection

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### Why we carried out this inspection

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This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

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### How we carried out this inspection

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We looked at the personal care or treatment records of people who use the service, carried out a visit on 26 September 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and talked with staff.

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### What people told us and what we found

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In this report the name of a registered manager appears who was not in post and not managing the regulatory activities at the time of our inspection. Their name appears because they were still the manager on our register at the time. The new manager Zoe Bradbrook-Henry had been in post for twelve weeks and had submitted their application for registration.

People living at Victoria Mews had dementia care needs. We spent time observing the care and support they received. We spoke with three visiting relatives, two staff members, the manager of the home and the area quality manager.

Relatives spoke positively about the care their family members received. One relative told us, "We come every day. There isn't a day we don't come and every day we are welcome. It is a really warm and wonderful place and I really enjoy coming here."

Care plans were in place to provide staff with information about how they were to support people. Some care plans did not always address risks to the health and welfare of people.

Comments we received about staff from visiting relatives were positive. One relative told us, "They are all lovely. They are really caring. They are all good." Another visitor described staff as "very obliging". We were satisfied staff knew how to respond to potential safeguarding concerns.

There was a process in place for dealing with and responding to complaints. A relative said, "If we have had anything to say it has always been resolved there and then."

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

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## **What we have told the provider to do**

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We have asked the provider to send us a report by 25 October 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

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

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## **More information about the provider**

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

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

## Our judgements for each standard inspected

### Consent to care and treatment

✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

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### Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

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### Reasons for our judgement

Staff we spoke with understood the importance of ensuring they had people's consent before providing care and support. We asked about how they ensured they had a person's consent when they had limited communication. One staff member told us, "Sometimes it is quite hard because a few don't communicate. You sort of know if they aren't happy. You get to know the residents. For example X will do things with her eyes and smile. It is really knowing your residents." Another staff member told us, "You have to know the resident. It is their body language. If I think somebody isn't happy about something I would go to my senior. It is knowing the resident and reading the care plan."

We looked at whether staff understood the Mental Capacity Act and how the Act might impact on their practice. The Mental Capacity Act 2005 protects people who may lack capacity to make some decisions themselves. Records confirmed that most staff had completed training in the Mental Capacity Act.

Care files we looked at did not always have assessments to determine whether people had the capacity to make decisions. The provider may find it useful to note that such assessments would provide staff with information about whether people had capacity to make decisions and whether that capacity was constant or fluctuated.

We discussed with staff what they would do if a person refused the support outlined in their care plan. One staff member told us, "I would report it to a senior. It is their choice to refuse. It could be detrimental to their health so it would have to be discussed to see how we could get round it for the health of the resident. You can usually get round it. Their key worker tries to get close to them. There is usually a strategy to get them to have a bath. Most of it is patience." Another staff member told us, "Encourage them to have it done but you can't force them. You definitely can't force them. I would let the senior know and document it in their care plan. If it continued you would have to let the family know."

One visiting relative whose family member had recently moved to the home told us they had been involved with care planning. They told us, "They gave us the 'Get to Know You'

form and then sat down and went through it with us." They told us how their family member had not liked their room when they first moved to Victoria Mews. They said, "We had a meeting with the manager. We said she didn't like her room so they moved her straightaway."

We saw that people had regular reviews of their care needs with family members being present. People or their relatives had not always signed the care review forms. The provider may find it useful to note that obtaining the signatures of people or their relatives would confirm they were happy with and consented to the care being provided.

We saw people or their family members had signed to consent to flu vaccinations.

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

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**Our judgement**

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The provider was not meeting this standard.

Care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

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**Reasons for our judgement**

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Whilst people were able to chat with us as we moved around the home, due to their dementia care needs they were unable to share their experiences of living there. We therefore carried out periods of observations within the lounge and dining areas to see what their experience was like living at Victoria Mews. We also talked to three visiting relatives to the home who spoke positively about the care their family member received.

"X always said they wouldn't go into a home but they settled here within two weeks."

"We can't fault it. She is being well looked after."

"I can't fault it. I just think they all know what she likes. It is nice to see how quickly they have got to know her."

"They make her laugh which is the main thing."

We observed that people generally looked well cared for with clean clothes, hair and nails. One visitor described their relative as "spotless" and said, "She has her hair done every week."

We looked at four people's care plans, three in detail. We saw that people had an assessment of their needs prior to moving to Victoria Mews. This was to ensure the home could meet their needs prior to a decision being made about moving there. The assessments were used to develop care plans and record people's preferences for everyday life. We saw one person's assessment had identified a specific personal care need that had not been put in their care plan. Staff had not been providing the care identified which we observed had compromised that person's dignity.

Care plans were available for most of the identified needs of each person and provided staff with sufficient information about how they were to deliver support in a way people preferred. We saw risk assessments had been carried out for people when there were

risks associated with their care. Care plans and risk assessments were reviewed regularly.

In the records we looked at in detail, we noted two instances where there was no clear evidence that identified care needs had been fully responded to. The risk assessment tool for one person whose care records we looked at had identified they were at risk of developing pressure areas. There was a care plan in place dated 12 June 2013 which provided staff with information about how they were to deliver care to prevent pressure areas developing. We saw this person had an area where there had been a previous toe amputation and there was a healing wound on their foot. The District Nurse had requested a hospital bed for that person. There was nothing in the care plan about the hospital bed and how this equipment should be used to prevent further damage to the skin.

For another person whose care records we looked at we saw a risk assessment dated 31 July 2013 which stated their risk of developing pressure areas was very high. We saw that person had developed a red and sore area to their skin on 17 August 2013. When staff had reviewed the risk assessment on 30 August 2013 the change to that person's skin had not been recorded and the risk assessment had reduced from very high to high. The red marks to this person's skin had not been recorded on a body map. No additional actions had been put in place to make sure the risk of harm to the person was appropriately managed.

Records demonstrated that people were referred to external healthcare professionals if a need was identified. We saw people had received treatment from the GP, dietician, dentist and optician. District nurses were also involved in the care and treatment of people living in the home. One relative told us, "X has a nurse coming in every day." Another relative told us, "If a doctor comes out to see X they tell us."

At lunch time we saw that tables were laid nicely with tablecloths, place mats, cutlery and condiments. It was pleasing to see that most people were supported to take their lunch together in the dining room. However, the lunch time was very noisy and at times appeared disorganised. We saw that some people were able to eat independently while others required a range of assistance from prompting and encouragement through to supervision and full support. We saw that staff struggled to keep an eye on people and also assist people who were unable to eat independently. For example, we saw two staff go to assist one person to eat. On both occasions the staff member had to leave that person to go and assist other people who had become agitated during the meal. Another staff member was supporting two people to eat at the same time. This meant neither person had the staff member's full attention.

The lunch time lasted a long time because of the time it took for everyone to be served and because of the time it took staff to help a large number of people to eat. We observed several people wandered off before puddings had been served. We looked at the care plan for one of those people who left the table before they had finished their meal. We saw they were at high risk of malnutrition and had been referred to a dietician. Their nutritional support plan stated "encourage to complete meals as will wander off".

We saw one person was very anxious throughout the course of our visit. There was a care plan in place to support this person's psychological needs. We observed some staff were more confident than others at engaging with this person to distract them from their anxieties.

We saw there were a range of activities available for people. On the morning of our visit

some people joined in movement to music. The manager explained this was particularly useful in improving people's balance and thereby aiming to reduce the number of falls in the home. The manager told us they had also introduced a pub night and "Fit as Fiddle" with Age UK was due to start in October. The service was looking into plans to develop a sensory area in the garden. The manager told us, "We need to make it their own home – make them feel as if they belong."

**People should be protected from abuse and staff should respect their human rights**

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## **Our judgement**

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The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

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## **Reasons for our judgement**

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We saw there was a safeguarding policy in place so that staff knew what should happen if they witnessed or suspected abuse. We saw that each member of staff had signed to confirm they had read the policy.

Staff we spoke with had a good understanding of what constituted abuse. Staff told us they had completed safeguarding vulnerable adults training to enable them to recognise abuse. They understood their responsibilities to report this. Records we saw confirmed that staff had completed safeguarding training. Guidance about local safeguarding contact numbers was displayed and accessible in the staff work station.

During our visit the manager shared information with us about a concern that had been reported to the local authority. The matter was being dealt with by the safeguarding team but had not been reported to us by the home as required. The manager explained that they believed we had been notified by the organisation that had raised the concern. The provider may find it useful to note that it is a requirement that all safeguarding issues or allegations of abuse are reported to the Care Quality Commission so that we can confirm they are being managed appropriately.

We spoke with staff about whistle blowing. The provider may find it useful to note that not all staff had a full understanding of the whistle blowing procedure. This could mean they would not feel confident to report any concerns under that procedure.

We looked at two staff files and found that all of the required recruitment checks had been completed. These included criminal records bureau (CRB) checks to ensure people were deemed safe to work with vulnerable adults.

Relatives we spoke with told us they could visit the home at any time they chose. One visitor told us, "Anytime. We have come at lunch time and they have made us lunch. We have come at 8.00pm." They went on to say, "We come every day. There isn't a day we don't come and every day we are welcome. It is a really warm and wonderful place and I really enjoy coming here." Another visitor told us, "We can visit whenever we want to." They confirmed that they felt their relative was safe at Victoria Mews.

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

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## **Our judgement**

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The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

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## **Reasons for our judgement**

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At the time of our visit there were 25 people living at Victoria Mews. We asked the manager about staffing levels for the home. She told us there were five care staff on duty during the morning shift from 8.00am to 3.00pm and five care staff on the late shift from 3.00pm to 10.00pm. One member of care staff was a senior on each shift. At night time there were three care staff on duty. The manager worked from Monday to Friday and was supernumerary. The deputy manager worked as a senior on the floor but was provided two days each week protected time in the office where they did not work as part of the shift. This enabled them to spend time completing tasks associated with their role. There was also dedicated ancillary staff that included an activities co-ordinator, domestics, kitchen staff, an administrator and a maintenance person. The level of ancillary staff ensured that care staff were able to spend most of their time delivering care for the people who lived there.

We saw rotas that confirmed the number of staff on duty were in accordance with what we were told.

The manager told us that the service only used agency staff occasionally. Three new bank staff had recently been recruited to cover staff absence. One staff member told us that agency staff were "not used very often at all. They ask bank staff first."

During our visit we observed staff were relaxed and friendly in their approach to people. Staff were available to meet people's needs. At lunch time we saw that some people required a high degree of support and supervision to eat their meal. The provider may find it useful to note that we observed it was a challenge for staff to provide the level of support and observation required. One member of staff told us that some days meal times could be very difficult and "other days it can be OK."

Comments we received about staff from visiting relatives to the home were positive. One relative told us, "They are all lovely. They are really caring. They are all good." Another visitor described staff as "very obliging".

We saw that new staff had a comprehensive induction when they started to work for the service.

Staff told us and records confirmed that most staff were up to date with their mandatory training. A record of training was maintained so the manager was aware when training was due to be renewed to ensure staff kept their training up to date. One staff member told us, "We have always got training on. It is constant." They told us they were due to start a three day dignity champions course to meet the specific needs of the people living at Victoria Mews. We saw that several staff had attained a National Vocational Qualification (NVQ) in care to help them provide more effective care to people.

Staff told us they attended regular supervision sessions with their manager. They also had annual appraisals when their training and development needs were discussed.

Staff we spoke with told us they felt supported by senior staff. One staff member told us, "She (the manager) has only been here a while but she is good. You can talk to her a lot." Another said, "if I have got a problem I now I can speak to Zoe."

**People should have their complaints listened to and acted on properly**

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**Our judgement**

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The provider was meeting this standard.

There was an effective complaints system available.

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**Reasons for our judgement**

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Victoria Mews had a complaints policy which set out how complaints would be responded to and the timescale for that response. Information about how to raise a complaint was displayed in the entrance hall to the home. It was also set out in the residents guide, a copy of which was available in the entrance hall.

We saw that a log of complaints was maintained. We looked at the last complaint raised and saw that it had been appropriately investigated and responded to. The manager explained that all complaints were put directly on to a risk management computer system. The provider was able to oversee the management of complaints to ensure they were dealt with in accordance with the complaints policy.

We asked relatives what they would do if they wanted to complain. One relative told us they would go to speak to Zoe the manager. They told us, "She has made that very clear. If we have had anything to say it has always been resolved there and then."

We saw that relatives meetings were held monthly. This provided family members with an opportunity to raise any issues informally. A relative we spoke with confirmed they attended the meetings. We also saw there was a book available in the entrance hall where people and visitors to the home could record any compliments or concerns they may have.

This section is primarily information for the provider

## ✕ Action we have told the provider to take

### Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<b>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</b> <b>Care and welfare of people who use services</b>
	<b>How the regulation was not being met:</b> The registered provider did not always assess, plan and deliver care in such a way as to ensure the welfare and safety of people using the service. Regulation 9(1)(a)(b).

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 by 25 October 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

## About CQC inspections

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

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

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

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

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

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

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

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

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

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

## How we define our judgements

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

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

**✓ Met this standard** This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.

**✗ Action needed** This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.

**✗ Enforcement action taken** If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

## How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

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

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

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

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

## Glossary of terms we use in this report

### Essential standard

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

Respecting and involving people who use services - Outcome 1 (Regulation 17)

Consent to care and treatment - Outcome 2 (Regulation 18)

Care and welfare of people who use services - Outcome 4 (Regulation 9)

Meeting Nutritional Needs - Outcome 5 (Regulation 14)

Cooperating with other providers - Outcome 6 (Regulation 24)

Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)

Cleanliness and infection control - Outcome 8 (Regulation 12)

Management of medicines - Outcome 9 (Regulation 13)

Safety and suitability of premises - Outcome 10 (Regulation 15)

Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)

Requirements relating to workers - Outcome 12 (Regulation 21)

Staffing - Outcome 13 (Regulation 22)

Supporting Staff - Outcome 14 (Regulation 23)

Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)

Complaints - Outcome 17 (Regulation 19)

Records - Outcome 21 (Regulation 20)

### Regulated activity

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

## Glossary of terms we use in this report (continued)

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### **(Registered) Provider**

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

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### **Regulations**

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

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### **Responsive inspection**

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

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### **Routine inspection**

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

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### **Themed inspection**

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

## Contact us

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