Care Quality Commission

Sharda Care Limited

Victoria Care Centre

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Requires improvement

Overall summary

We undertook an unannounced focused inspection on the 5 November 2015 in response to an incident that took place at the home on the 9 October 2015. After the incident the provider wrote to us to tell us what they would do and had done to make sure people were safe and to minimise and manage the risk of a similar incident happening again. We carried out this focused inspection to assess the safety of people using the services, to check the provider had followed their action plan and to make a judgement as to whether the provider was meeting legal requirements.

This report only covers our findings in relation to the safety topic area. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Victoria Care Centre on our website at www.cqc.org.uk.

At our last inspection in June 2015 we rated the service as good in the five topic areas; safe, effective, caring, responsive and well-led and in the overall rating.

Victoria Care Centre provides accommodation and personal and nursing care for up to 115 people some of whom may have dementia or physical disabilities. The home is purpose built and located in north west London. Public transport is accessible and there are shops within walking distance of the service.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission [CQC] to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During our focused inspection on the 5 November 2015, we found that the provider had followed their plan. However there were areas where we found shortfalls and legal requirements had not been met.

Summary of findings

There were systems in place to keep people safe. We found prompt action had been taken following the incident to make the environment more safe and secure. A protocol was in place for staff to follow to minimise the risk of a similar incident occurring. Communication between staff about peoples' needs including their behaviour needs had improved since the incident. Further appropriate staff training had taken place. A range of monitoring safety checks were being carried out and improvements made when required.

However, there were some areas of safety that required improvement. The registered person had not fully protected people against the risks associated with their safety as some records including incident records were incomplete, which meant it was not evident that appropriate action had been taken to review them and put specific strategies and guidance in place in place to minimise the risk of them occurring again.

We found adequate systems were not in place to maintain an accurate, complete record in respect of people, including decisions taken in relation to the care and treatment provided. People's care was recorded in both computer and paper format. Information about aspects of people's care was not always easy to access as computer and paper care records did not always include the same information, including up to date information which could affect the safe delivery of care to people.

Arrangements were not in place to ensure that staff received specific mental health training to support them in being skilled and competent to care for people who had been admitted to the home with significant mental health and behaviour needs and to keep them safe.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

We found aspects of the service were not safe. Improvements had been made to some guidance, checks and communication between staff to improve the safety for people who used the service.

However, people were not fully protected people against the risks associated with their safety. Systems in place did not effectively assess and manage the risk of people using the service. Some records were incomplete and did not include details of staff action to minimise the risks for people to keep them safe.

There were not adequate systems in place to maintain an accurate, complete record in respect of each person, including decisions taken in relation to the care and treatment provided. Accessing specific information about people's risk assessment and care was at times quite challenging due to the record keeping systems.

Requires improvement

Victoria Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook a focused inspection of Victoria Care Centre on 5 November 2015. This inspection was completed to check that following an incident at the service people living in the home were receiving safe, care and treatment.

We inspected the service against aspects of one of the five questions we ask about services: is the service safe and effective.

The inspection was undertaken by one inspector and one inspection manager.

Before our inspection we reviewed the information we held about the home, this included the provider's action plan which they had completed and update following the incident, which set out the action they had taken and planned to take to show they met legal requirements in providing care and treatment in a safe way.

We spoke with the registered manager, two directors, a unit manager, a nurse, two care workers and a maintenance person. We also checked a reviewed four people's care plans, people's risk assessments, incident records, staff training records and records relating to the management of the service including monitoring checks.

Requires improvement

Is the service safe?

Our findings

The manager had taken some action following the incident however there was still a lack of arrangements or systems in place to effectively assess and manage the risk of people using the service.

The registered manager told us that people's environmental risk assessments had been reviewed. However, not every person had received an assessment of their risk of falling or jumping out of a window. The registered manager told us that people who were assessed as a higher risk than others, such as people who challenged the service, had received this risk assessment and staff were still in the process of completing these risk assessments for all other people living in the home.

When reviewing people's risk assessments, information was difficult to follow as computer records had only set areas of risk assessment. Therefore, when staff needed to assess people's additional risks, such as risks to do with people's behaviour and self- harm, these had to be documented on a separate hand written risk assessment record. For one person using the service, staff had only completed a separate hand written risk assessment about a person's risk of falls from a window. This window risk assessment was linked to a hand written behaviour chart for the person. So staff who looked only at the person's computer records would not have access to this information and would not be aware of how to meet the person's specific care and risk assessment needs. For another person, their risk assessments were recorded on the computer but these lacked detail including the specific action staff needed to take to manage risks. We needed to refer to the person's care plan to find this information.

The above evidence demonstrates that the assessment and management of risks to the health and safety of people using the service was not being done appropriately which could risk people receiving support that was not appropriate and unsafe.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014

A unit manager told us that a review of a person's needs had not been carried out prior to an incident but currently staff promptly reviewed peoples' needs when their behaviour changed. They told us that all the people who were receiving 1-1 care had had their care needs reviewed with health professionals since the incident, and that staff had commenced reviewing all other people's care and risk assessment needs.

Staff we spoke with told us there was good communication between the staff team about people's needs and confirmed they discussed people's 1-1 care and support. A unit manager confirmed that people's behaviour and any changes were discussed during staff handover meetings. They told us protocols for 1-1 care for people were in place, but these were not recorded, which meant there was no specific written guidance for staff to follow when supporting people with 1-1 care so staff may be at risk of not providing people with the care and support they needed.

Staff told us about the changes and improvements that had been made since the incident. They told us that when they provided people with 1-1 care and support they were now asked questions by senior staff about the people they supported to test their knowledge about the person and their needs. The staff said this had helped them to get to know each person more fully, have more understanding of their requirements and so be more competent in providing people with the care they needed. However, these questions and answers were not recorded so there was no information that identified where staff knowledge about a person had been lacking and where they needed to develop their understanding of the person's needs.

People's records were documented using two systems, computer and paper format. We found it difficult and time consuming accessing some aspects of information about people's care. This was because some people's care records were in one system and not in the other so both systems needed to be accessed to obtain a comprehensive record of people's care. The detail in the care records was not consistent in each system, so staff accessing a person's computer records might not be aware of up to date information recorded in another system, which could affect the safety of the care they provided for people.

We asked to see a care plan that covered the 1-1 care and guidance for addressing a person's aggressive behaviour. We were told by the unit manager there was a care plan that addressed this behaviour but they were unable to locate it at the time we asked to see it. We recognise when we asked to see this care plan that at the same time we were asking staff for other information, but further

Is the service safe?

indicates the difficulty in accessing specific information about people, and the need for staff to spend sometimes significant time locating information about people. Following the inspection the registered manager informed us this specific care plan had been located.

Accidents and incidents were recorded and records showed healthcare professionals including GP and psychiatrists, mental health care manager's had been contacted in response to incidents when people's behaviour challenged the service. For example two people had been visited by a mental health team staff member when staff had concerns about their behaviour. Records showed in response to a person's change in behaviour the registered manager had requested a review of a person's needs. However, two incident records we looked at had partially been completed and did not record the action taken by the manager following the incidents. Another incident record did not show that the person's care manager had been informed.

A nurse told us that staff had always been good at reporting incidents but had recently been reminded of reporting to nurses and/or other senior staff any alarming or unusual, to follow emergency procedures and the need to press the emergency button. Care workers we spoke with knew about these emergency protocols.

In the care plans we looked at we also found records that showed staff had contacted appropriate health and a social care professionals [multi-disciplinary team MDT] when people were unwell and/or exhibited behaviour that challenged the service. However, some visits and other contact by health professionals were hand written, some were recorded on the computer system and some recorded on both, so staff could have difficulty accessing the most up to date information about a person. We were provided with a person's computer care records dated 10/10/15 but we were unable to locate records of the visits or details of the person's behaviour that we had seen in the person's written paper records. This was a further example of the shortfalls in having two systems of care records which did not always include the same information about people.

The registered manager told us that the systems were "confusing" and information "all over the place." He spoke of reviewing and improving the systems for recording and monitoring people's care.

These examples above indicate a shortfall in the maintenance of accurate complete records and the decisions taken in relation to the care and treatment provided to people.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014

The registered manager told us that since the incident eight staff had received challenging behaviour and dementia training. A unit manager and two care workers confirmed they had completed this training and a nurse told us that the training "had been very useful." The registered manager told us that further training including self-harm behaviour was planned for all staff. We found no record of staff having received specific mental health training despite some people living in the home having mental health needs and at times exhibited behaviour that challenged the service. Records showed that the topic of mental health was included as part of one standard of the Care Certificate induction, completed by some staff and some aspects such as depression were included in dementia care training. The registered manager told us that they would arrange mental health training for staff and said the service was currently not admitting people who had mental health needs.

Staff we spoke with were aware of the emergency protocol including reporting procedures which the manager had put in place since the incident. A care worker told us "We never assume anything and report anything we feel is not right." They told us they discussed people's needs including behaviour needs during staff 'handovers', staff meetings, twice daily 'team briefings' and group supervisions. A nurse told us they always updated people's care plans when their needs including behaviour changed and made sure this was communicated to staff. They told us since the incident there had been "More discussions about behaviour and safety." A care worker told us that communication about people was now "much better." Care workers told us that people's risk assessments had improved and they made sure they read people's care plans and spoke with people and their relatives to gain a good understanding of their needs. Care plans and general risk assessments such as falls, nutritional and mobility showed they had been recently reviewed, and they included guidance for staff to follow to provide the care people needed safely.

Staff told us they felt there were sufficient staff on duty during each shift to provide people with the care they

Requires improvement

Is the service safe?

needed. They confirmed staffing was flexible to make sure people received 1-1 care when they required and so people had staff support to attend appointments. A nurse told us agency staff received an induction when they started work. They told us that when needed, regular agency staff were employed to ensure they were familiar to people using the service and understood their needs. They said there was also a 'floater' care worker who supported staff on any unit where they were most needed. The registered manager informed us that there were currently two unit managers each covering two units. He told us that there were plans to recruit a further two unit managers so that there would be one unit manager responsible for each unit, who would carry out a range of duties including managing the staffing needs, reviewing care plans and completing quality checks.

The registered manager and the maintenance person told us that additional robust window restrictors had been fixed to each window in the home. During this focused inspection we checked a number of windows on each floor of the home. These included people's bedroom windows, windows located in unit lounges and in stairways. We found additional window restrictors had been attached securely to each window that we looked at. The windows we checked showed that they did not open further than 10 centimetres which met suitable control measures to minimise the risk of falls from windows. We were shown by the maintenance person a window in the 4th floor lounge which also had an added wooden restrictor to further minimise the risk of the window being forcibly opened. The maintenance person told us placing these on each window was being considered by the service as an added risk control measure.

We found there were additional window restrictor safety checks being made and a new risk assessment for windows and doors dated 11/10/2015 was in place. Records showed that weekly checks of all the windows were now being carried out. Prior to the incident, records showed monthly checks had been completed and that no faults had been found with the window restrictor fixtures since these checks had commenced at the time they had been first fitted.

We also looked at the 1st and 4th floor terraces action had been taken to review the safety of people who accessed to them. Each terrace had an anti-climb fixture on the top the surrounding wall. Chairs and tables had been secured so people could not access them without staff support, to minimise the risk of this furniture being used as a platform to stand on and risk falling. The ladder from the 4th floor since the incident had been made not accessible to people using the service, so minimised further the risk of falls.

We were shown fire safety records. This covered a fire risk assessment, a fire evacuation plan for each person, records of fire drills, weekly checks and records of fire alarm system and fire extinguisher external checks. Environmental risk assessments included a range of areas to do with the service including management of people's food, medicines, rooms and water checks. Theses checks were comprehensive and showed action had been taken to make improvements. This included completing repairs, replacing light bulbs, and adjusting fire doors for people's safety.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person was not doing all that is reasonably practicable to mitigate the risks to the health and safety of people. Arrangements were not in place to ensure that staff received the specific training they needed to be competent and skilled to provide care and treatment to people safely. Regulation 12 (2) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have adequate systems in place to maintain an accurate, complete record in respect of each person, including a decisions taken in relation to the care and treatment provided. Regulation 17 (2) (c)