Serving All Limited

Vauxhall Court Care Home

Inspection report

Vauxhall Court Residential Care Home
Vauxhall House, Freiston Road
Boston
Lincolnshire
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Tel: 01205354911

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12 October 2022

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21 November 2022

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Vauxhall Court Care Home is a residential care home providing accommodation for persons who require nursing or personal care to up to 33 people. The service provides support to older people, including people living with dementia. At the time of our inspection there were 28 people using the service.

People's experience of using this service and what we found
Medicines were not always managed safely. Prescribed medicines were not always in stock which meant at times people had not been administered all their medicines.

Risk assessments were not in place to mitigate risk to staff and people receiving care and support.

Care plans did not always contain the most up to date information to ensure staff were meeting people's needs.

The provider's mandatory training was not completed by all staff. Staff did not recognise the importance of having the appropriate training and skills to safely support people.

The management team completed regular spot checks including at night. This supported ongoing improvements in the quality of care people were receiving.

There were procedures to identify when people needed safeguarding and staff understood their responsibilities to keep people safe.

Improvements had been made since our last inspection. There were systems in place to improve the quality of the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 31 May 2022) and there were breaches of regulation. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We undertook a focused inspection to follow up the Warning Notices we previously served to check whether the provider now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We looked at infection prevention and control measures under the Safe key question. We look at this in all

care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Vauxhall Court Care Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, consent and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always Safe.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always Effective.

Details are in our Effective findings below.

Is the service well-led?

Requires Improvement

The service was not always Well-led.

Details are in our Well-led findings below.

Vauxhall Court Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
One inspector carried out the inspection and an Expert by Experience made calls to relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Vauxhall Court Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Vauxhall Court Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager was in post and had submitted an application to register. We are currently assessing this application.

Notice of inspection
This inspection was unannounced on the 11 October 2022 and announced on the 12 October 2022.

What we did before the inspection
We reviewed information we received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.

We requested feedback from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
We spoke with nine members of staff including the manager and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We spoke with two people who use the service about their experience of the care provided. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with one visiting professional.

We reviewed a range of records. This included three people's care records and 14 medicine records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

At our last inspection the provider failed to ensure medicines were always managed safely, lessons were not learnt, and risk management was not effective. This placed people at risk of harm. This was a breach of the regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● People's prescribed medicines were not always in stock. We found two people had not been administered some of their medicine for three days as the provider had not ensured it was available. Not being administered some of this medicine was detrimental to health including medicine to treat hypertension. This meant people were at risk of their health deteriorating.
● Medicine administration records (MARs) were not consistently completed. We found that one person had gaps in the records for supplements to help them maintain a healthy weight. Although staff told us they had failed to sign after giving them, the stock count did not corroborate that. We could not be assured people were always receiving their prescribed supplements which could result in weight loss.
● Medicines were not always stored in line with best practice. We checked five prescribed creams and found three did not have a date on them to state when they were opened and when they expired. By not following manufacturers guidelines, it increased the risk of medicines not being safe or effective.
● Most people's MARs were handwritten. Handwritten MARs were not signed by staff to show who had completed them and who had checked them. This meant we could not be assured an appropriate checking system was in place to verify MARs had been accurately completed.
● Controlled drugs were not managed in line with legislation. The Misuse of Drugs Act 1971 places controls on certain medicines which are called controlled drugs. Although two staff completed regular balance checks of controlled medicines kept in the home, we found controlled medicines still in stock for people who were no longer using the service. This meant the provider was not always following guidelines for the storage of controlled medicines.

The provider failed to ensure medicines were always managed safely. This placed people at risk of harm. This is a breach of the regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some improvements were identified in the management of medicine. We found 'as required' (PRN) medicines had protocols for when they should be given. This meant staff had clear guidelines to ensure people were receiving medicine when they needed it.

Preventing and controlling infection; Assessing risk, safety monitoring and management
● Prescribed creams for people were all stored together. We checked one medicine trolley that stored 11 people's medicines and found prescribed creams were stored together in one container. This created a risk of cross contamination and was a potential risk for spreading infections.
● Staff were not always wearing personal protective equipment (PPE) in line with government guidelines. We saw a member of staff not wearing a mask and some staff not wearing masks over their nose, mouth and chin. This meant staff were not following procedures to prevent the spread of infections which put people at risk.
● People's laundry was washed together. We saw that people's linen was all washed together which does not safeguard against the risks of spreading potential infections. A relative told us, "The laundry is disgusting, it has been washed but it is not cleaned properly."
● Not all staff had received training in basic food hygiene. Some staff including a kitchen assistant had not completed basic food hygiene training. Basic food hygiene helps staff to understand how to prevent cross-contamination and maintain good personal hygiene when working with food.
● Procedures were not in place to ensure daily checks were carried out in the kitchen. For example, when a regular cook was not at work, we saw food temperatures and fridge temperatures were not recorded. This meant we could not be assured food had been cooked or stored safely.
● Environmental risk assessments had not been completed. These are carried out to assess potential risks that would be identified in a care home. The provider should ensure they are delivering a safe workplace for staff and people should be receiving safe care and support in a safe environment. If risk is not safely managed, it could result in harm to staff and people who use the service.
● Personal emergency evacuation plans (PEEPs) did not contain enough detail. We reviewed three people's PEEPs and found they did not contain information about where the nearest evacuation point from their bedroom would be or where equipment needed to evacuate the person was located. This meant we could not be assured staff would be able to safely evacuate people in an emergency.

The provider failed to ensure they were preventing and controlling infections and managing risk to ensure people's safety. This placed people and staff at risk of harm. This is a breach of the regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Most individual risks to people had been assessed and actions were in place to mitigate any risk. For example, risk assessments had been carried out for people who required bed rails to keep them safe alongside initial bed rails assessments to ensure they were safe to use.
● The maintenance team completed regular safety checks. This included regular health and safety checks and walk arounds to assess the environment and identify anything that required action. The team had created an action plan which was regularly updated to show improvements that had been made in the home.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider failed to report incidents to the local authority safeguarding team. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

● Although improvements had been made, some relatives were not confident about reporting concerns. One relative told us, "I would know who to speak to, but staff are not very welcoming. They were welcoming to my relative but not to me." We have reported on this more in the well-led section of the report.
● Most staff had completed safeguarding training. We found some new staff still needed to complete training, however there were planned training dates to ensure this was done. This meant staff had the knowledge to identify concerns and report them.
● The provider had reported concerns to the local authority and notified the Care Quality Commission when appropriate. Statutory notifications ensure that details of certain incidents, events and changes that affect a service, or the people using it, are notified to the Care Quality Commission.

Learning lessons when things go wrong
● A system was in place to record when things had gone wrong or concerns had been raised. However, the system only recorded actions taken, it did not allow for clear learning and development.
● The provider was responsive to feedback. We saw evidence they had responded to an audit from the local authority by making recommended changes to improve the service.

Staffing and recruitment
● We reviewed four weeks of rotas and observed there were high numbers of staff sickness. A member of staff told us, "There isn't always enough staff on shift when people ring in sick. I've been on shift where there have been 2-3 people here." The rotas showed the management team often covered shortfalls in staffing and most relatives that provided feedback did not have any concerns about staffing. One family member told us, "There seems to be enough staff. If [relative] needs anything they will come straight away." During inspection, we observed people receiving support when they required it.
● The provider used a dependency tool to determine how many staff were needed each shift. Each day shift was managed by a senior carer and two managers were on site most days during the week to provide support and guidance.
● An on-call duty rota was in place to ensure night carers had management support when needed. We saw this was rotated between managers and a team leader. This ensured consistent support for staff to enable them to safely carry out their role.
● The provider had followed safe recruitment processes such as obtaining references and carrying out checks with the Disclosure and Barring Service (DBS) as part of their recruitment process. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Visiting in care homes
The provider had visiting arrangements in place that aligned to government guidance.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

At our last inspection the provider failed to support people with appropriate or specific mental capacity assessments related to their care. This was a breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 11.

- The provider lacked understanding of how to apply the principles of the MCA. The provider had carried out one capacity assessment for each person which was considered as an overarching assessment for any decisions that needed to be made. The MCA applies to situations where a person may be unable to make a particular decision at a particular time but does not mean a person lacks capacity to make any decisions at all.
- Best interests decisions had not always been carried out to demonstrate decisions had been made in people's best interests. For example, the provider had asked relatives to sign consent forms for the use of CCTV in communal areas and for the use of bed rails. Best interests is a statutory principle set out in the MCA.

The provider had not ensured specific mental capacity assessments had been completed with people when

a decision needed to be made. This was a breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following feedback, the provider told us they had sourced training for the management team to gain more understanding about the MCA.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Assessments were not always completed accurately. We saw a Waterlow score assessment for pressure area risk which had not been scored correctly. The Waterlow score assessment is a scoring system that incorporates various factors to assess the risk of a person developing pressure sores. This meant the person was at increased risk as they had not been assessed properly.
● Care plans were reviewed regularly. However, changes to people's care needs after reviews were put on a separate document and were not always incorporated into the care plan. This meant it often looked like information was not up to date. This meant staff may not be aware of the most relevant information about people.
● Care plans contained sufficient information about people's needs and preferences. We saw examples of personal preferences being incorporated into plans to show what people wanted. This supported people's quality of life and sense of control over their care and support needs.

Staff support: induction, training, skills and experience
● Most staff had not completed training which was specific to the health needs of people they supported. This included dementia, diabetes, epilepsy and Parkinson's disease training. This meant staff potentially did not have the appropriate knowledge to understand people's complex needs.
● Staff had completed most of the mandatory training that was requested by the provider. Training was a mix of online and face to face training with an instructor. We saw that further training sessions had been organised to ensure gaps in staff training were being addressed.
● New staff completed induction training. Staff completed the Care Certificate as part of their induction. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
● Staff received regular supervisions. These gave staff the opportunity to discuss any concerns and to consider further areas of interest and training.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The provider worked well with other agencies to ensure people had appropriate care. The provider had recently implemented a weekly ward round with the care co-ordinator. These showed that concerns relating to people's health were being discussed and appropriate referrals had been made to ensure people were being supported with their changing health needs.
● We spoke to a district nurse who visited the home regularly. They told us, "We all work together. It's one of the main care homes I visit, and I think they do a really good job. We work together to ensure residents are well supported."

Supporting people to eat and drink enough to maintain a balanced diet
● People who had lost weight were reviewed to consider why that was happening. For example, one person who had lost a significant amount of weight was seen to eat better when they were encouraged to eat in the dining room. Staff told us they now supported that person to eat in the dining room as much as possible, although still respected the person's choice.

● Kitchen staff had good knowledge of people and their needs. We saw a list of dietary requirements displayed in the kitchen which ensured staff had the appropriate information on people's individual dietary needs or modified diets.
● People had choice of what they wanted to eat. Staff told us they asked people individually what they would like out of two options, however explained people could request something else. This supported people's choice and control over what they wanted to eat.
● There was consideration for people with cognitive impairments when choosing meals. For example, when people suffered with short term memory loss, the provider told us they ensured people were asked what they'd like nearer to mealtimes to prevent confusion.

Adapting service, design, decoration to meet people's needs
● The building was on one level which supported people's needs. Most people had cognitive or physical impairments which meant the ground level design was safe and accessible.
● Visual aids were displayed around the home to support people's understanding of their environment. We saw colour coded signs to easily show where toilets and bathrooms were. This supported people with visual and cognitive impairments.
● Fire exits and external doors had alarms on them to alert staff when people had opened them. In the past people had left the building unattended which was unsafe. The alarms ensured staff were aware when doors had been opened without restricting people's movements. We saw people freely walking around the home and enjoying the garden.
● The care home had a large outside area. Some of the grounds had been developed so people could enjoy the outside space. For example, there was a large summer house that staff told us people liked using for some peace and quiet. The provider told us there were further plans to develop more of the outside area.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection systems were either not in place or robust enough to demonstrate safety was effectively managed. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The provider had not taken all the actions required to demonstrate people always received high quality, safe care and support. The continued breach of some of the regulations demonstrated further improvements were needed.
- The systems to review quality and safety were not always effective. For example, ABC forms, which are a way of recording information when a person is distressed, were not analysed or reviewed to ensure interventions or actions from staff were appropriate or best practice. This meant there was insufficient oversight when people were in distress to help staff understand what they could do better to improve the situation for people in the future.
- The provider had not ensured the care and support people received was consistently safe. For example, only the management team administered medicine, however no one had identified when medicine was not in stock and needed to be followed up with the pharmacy or GP.
- Environmental checks had not always taken place to ensure timely support was being provided when people needed it. For example, although an electronic system was in place to enable call bells audits, the provider had not considered to audit these to ensure staff were responding quickly when people were asking for support.
- We acknowledge the management team had made some improvements and addressed some of the concerns raised at the last inspection. However, further improvements were required to ensure people consistently receive safe care and support.

Governance and service oversight were not always effective. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Regular spot checks were in place to review the quality of the service. We saw two examples of night

checks that had identified shortfalls in quality. The provider held staff meetings from these and discussed findings to help drive improvement.
● A clear management structure was in place. Although there wasn't a registered manager at the time of inspection, a manager was in post and had applied to the Care Quality Commission to be the registered manager. The manager was supported by a deputy manager.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Relatives raised concerns the management team were not accessible. One family member told us, "I don't know anything about the management, they don't come in to see you when you visit or introduce themselves." Another relative told us, "I have not complained as management are not accessible."
● People did not always feel involved with their family members care and support. One relative told us, "I was involved in nothing to do with [their] care. I did not know they were taken off [medicine] until yesterday."
● People were not actively involved in developing the service. The provider told us that most people had dementia and were unable to take part in resident's meetings. However there had been no attempts to make a resident meeting inclusive and accessible to everyone regardless of people's disabilities or medical conditions.
● The provider did not seek feedback from relatives. We spoke with ten relatives who all told us they had not attended a relatives meeting and were unaware of any being held. One person told us they had received a questionnaire a long time ago.
● There was no evidence staff were supported to give feedback or suggestions. There was no opportunity seen in staff meeting minutes where staff feedback had been requested.

The provider did not involve others. The provider did not consider people's equality characteristics to enable them to provide feedback and share their views. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● There wasn't always a positive culture that promoted person centred care. Several relatives told us their family members wore clothes that weren't their own and brand-new clothes had gone missing. One relative told us, "[Relative] is still wearing other people's clothes. Yesterday they wore a vest under a shirt, and they don't like wearing vests and don't own one."
● Managers were not always accessible. The manager's office was up a staircase on another level to the rest of the home. This meant staff had to leave the ground floor where people were supported to speak with them. There was a locked gate at the bottom of the staircase, which prevented people who lived at the service in accessing the manager's office. The location of the office did not support an inclusive or equal culture and made it difficult for managers to have full oversight of the service.
● The provider had strong values and a clear vision of how they wanted to develop the service. The provider told us they were working with staff to help them understand their values and embed them into practice to improve the quality of the service.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider understood their responsibility to be open and honest when something goes wrong. However, a relative told us, "The manager has not addressed our concerns and is now not answering my emails." Other relatives told us they were satisfied with management, one family member said, "I have been

encouraged by the home to raise any issues with them."

● The provider was open and honest during the inspection. The provider was working closely with the local authority to improve the quality of the service by working through an agreed action plan.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured specific mental capacity assessments had been completed with people when a decision needed to be made.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure medicines were always managed safely. The provider failed to ensure they were preventing and controlling infections and managing risk to ensure people's safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance and service oversight were not always effective. The provider did not involve others. The provider did not consider people's equality characteristics to enable them to provide feedback and share their views.