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Victoria Hall

Inspection report

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13 July 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Victoria Hall is a residential home which is registered to provide accommodation for up to 37 people. At the time of the inspection there were 30 people living in the service.

The service had a comprehensive inspection on 28 January and 5 February 2015 when we found four breaches of the regulations. These concerned staff recruitment, recording in care records, issues regarding the deprivation of people's liberties and assessment of their mental capacity. The provider wrote and told us what they would do to meet the legal requirements in relation to the breaches. We inspected the service again on 9 August 2016 and found the service still required improvements in three out of the five key areas we inspect against with one breach around failure to display their rating. This had been addressed in our most recent inspection.

We undertook a further unannounced comprehensive inspection on 11 and 13 July 2017 and found a number of concerns and breaches of the regulations. We had some immediate concerns about the premises, fire safety and events surrounding accidents. We brought this to the immediate attention of the manager to address. We then visited again with a fire officer from the local fire service. Some immediate remedial actions were taken but we still had concerns and wrote to the provider, telling them what concerns we had. We sought assurances from them that these would be addressed to ensure people were safe at the home.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission 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.

People were not adequately protected from risks to their safety. This was because risks were poorly managed and there was no evidence of lessons learnt in which the service changed their practices in light of an incident or accident. Our particular concerns were around fire safety, the maintenance of equipment and managing falls. We also had some concerns about poor infection control practices. We later received assurances from the manager that they had taken actions to address the safety issues which we found.

Staffing levels were not always adequately maintained across the day and additional staff were not available at busier times of the day. The provider did have a dependency tool but we found this unreliable in determining how many staff they needed to meet people's needs. This meant we could not be assured staffing levels were always adequate.

Staff were trained and assessed as competent to administer medications. However we found some gaps in record keeping which had not been identified by the service. This meant the medication audits were not as robust as we would expect.

The provider's recruitment process ensured that only staff that had been deemed suitable to work with people at the home were employed.

We were not assured people were always eating and drinking sufficiently. There were no adequate systems or ways of monitoring of this. We were not confident that people had their health care needs adequately and monitored and met. The service did not have robust records which would enable us to draw conclusions as to how people's health and care needs were being met.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We found that the registered manager understood legislation in relation to this. They had made a number of DoLS when required. The registered manager told us that applications had been submitted to the relevant local authorities and were awaiting the outcome of these.

Staff knew people well and were responsive to their needs. On the whole we saw staff interactions and practices were positive. However, we observed care that was not individualised or personalised.

Care records telling staff what people's needs were and how they should meet these needs were in place. However, these records contained a lot of generic information. They were not personal to individuals. Not all the information reflected people's current needs and we found records were not accessible. Records were kept in a number of different places and there was not always an accurate record of people's care needs.

There was a programme of activities but the service did not demonstrate that activities hours were sufficient to meet the social needs of people or give them sufficient opportunity to engage in meaningful activity.
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The service had a complaints procedure and complaints were responded to quickly. However we found that the responses did not indicate an open culture which welcomed feedback and helped the service to improve.

The manager was overseeing two services and we felt this contributed to them not having a clear overview of risk within this service. There was poor support from the provider and the monitoring of the service was not adequate. The analysis and overview of accidents and incidents was completed by staff employed by the company but not the manager. Therefore the manager was not able to respond to these incidents and take the appropriate action to prevent incidents from happening again.

Consultation with people using the service and other stake holders was poor and it was not clear how feedback helped to improve the service.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not sufficiently protected from risks to their health and safety.

Equipment was not always well maintained.

Accidents were poorly documented and staff did not always act in accordance with the provider's policy.

Fire safety was unsatisfactory.

There were not always sufficient staff to give timely care which was responsive to people's needs.

People received their medicines as intended. However medication records were not always signed to demonstrate medicines had been administered.

Staff recruitment procedures were adequate and helped ensure only suitable staff were employed.

Is the service effective?

Requires Improvement

The service was not always effective.

Risks in relation to people's hydration and nutrition were not adequately monitored, so people were not adequately protected from unplanned weight loss. This put people at risk.

Records did not always evidence that people got timely health care based on their changing needs.

Staff received adequate training and had the necessary support and supervision to assist with their role.

Staff had a basic knowledge and understanding of the requirements of the Mental Capacity Act 2005 but this was not always carried through in practice.

Is the service caring?

Requires Improvement

The service was mostly caring.

We observed some kind and caring interactions but this was not seen consistently across all the staff.

The service did not sufficiently take into account people's wishes and preferences.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive personalised care which was responsive to their needs.

Concerns and complaints were dealt with in a timely manner but not always responded to in a positive way..

Staff did not sufficiently support people to take part in regular activities.

Is the service well-led?

Inadequate

The service was not well- led.

The service was not open and inclusive.

Quality assurance systems were ineffective.

The service did not adequately consider the views of people using the service to ensure the service was personalised around their needs.

Victoria Hall

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 is 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.

This unannounced inspection took place on 11 and 13 July 2017 and was carried out by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we looked at information we held about the service including previous inspection reports and notifications. A notification is information about important events which the provider is required to tell us about by law. We also spoke with a health care professional and we received information from the quality monitoring team and the local authority's adult protection team. Following the first day of our inspection visit we spoke with the fire officer who visited with us on the second day. We also spoke with paramedics.

During the inspection we spoke with eight people living in the home, five relatives, the registered manager, five care staff and the cook. We also completed general observations during the inspection.

We looked at three people's care records, and specific records in relation to nutrition and falls. Staffing records and other records relating to the management of the business were also reviewed.

Inadequate

Is the service safe?

Our findings

At the last inspection safe was rated as requires improvement. This was because people were not always safely supported with taking their prescribed medicines. There was insufficient numbers of staff to keep people safe.

At this inspection we spoke with people about their experiences. We asked people if they felt safe in the service but found most people were not able to tell us. However, for those people we could communicate with they told us that they felt safe. One person said, "Yes, I feel safe here." A person's relative told us, "We have no safety concerns at all and our [relative] has never been mistreated."

At this inspection we found that the risks which people faced were not well managed and found the manager was not able to demonstrate that there were clear systems in place to assess, monitor and identify risks and take timely actions to address them. Records were not sufficiently robust showing what actions had been taken. This put people at risk and potential harm. For example on arriving at the service on our first day of inspection we were unable to establish exactly how many people were using the service as staff did not initially know. Staff when asked said one person was unwell and no one was currently in hospital. In fact towards the end of the day we found one person had been admitted to hospital two days previously after a series of falls and two people were being cared for in bed. Senior staff in charge of the unit were not aware of this information at the start of the shift. They were unable to provide us an up to date list of people using the service which meant in the event of a fire we could not be assured everyone would be accounted for.

Following the inspection we received concerns about the service in terms of the person who had been admitted to hospital. The paramedics had insufficient information about the person's needs and circumstances leading up to their admission. We also found it difficult to establish the facts as they were not supported by accurate and contemporaneous records.

Regular audits were completed on fire safety systems; equipment, lighting and ensuring staff understood the fire procedures. However we found fire doors propped open and automatic door closures were not working properly. We noted a fire extinguisher not secured to the wall and window restrictors broken. A fire door had a bolt across it which would not prevent evacuation but might slow it down. There were no individual personal evacuation plans for people who would need assistance to evacuate the building, in the event of an emergency. Following the inspection the manager told us there was information in people's care plans about fire evacuation. However this was not easily accessible to staff and in light of no accurate information about how many people lived at the service we had serious concerns about the implications of this. The fire plan was not accurate and we raised concerns with the fire officer about the fire zones. We brought this to the attention of the manager who took steps to deal with our concerns. When we visited for a second day with the fire officer some of these concerns had been addressed. However, we still found fire doors propped open. This meant in the event of a fire the fire would not be adequately contained.

We observed a cupboard open with cleaning materials visible. A product which is prescribed to individuals

who are at risk of choking, to thicken their drinks was left out and accessible to others. If consumed without the correct quantities of fluids this could cause a person to become unwell. The service was supporting people who were living with different forms of dementia and were at risk of ingesting this product. This was brought to the attention of the staff, so it could be locked away safely.

The service had some maintenance issues but was generally in a good state of repair and provided a pleasant environment for people to live in. Where repairs had been identified and reported to the maintenance person these had not been addressed in a timely way. We found a faulty fan extractor, two faulty bedrails, and broken window restrictors. This increased the risk of harm to people using the service.

People had risk assessments which specified the risks which people faced. However, insufficient action had been taken to respond to accidents and incidents. For example some people had repeated falls and this had not been sufficiently reviewed to consider any underlying causes or specify patterns to their falls. Bedrails when used were not used appropriately with correctly fitting bumpers which meant we saw a number of entries where people's limbs had become entrapped between the bed and bed rail resulting in minor injury, or discomfort. Two bedrails were broken and had been reported as such but not been dealt with. This put people at further risk of experiencing harm.

There was poor monitoring of changes to people's weight which meant the service was not quickly identifying when people had unplanned weight loss. This meant timely actions to address this had not been taken. The service told us that no one had pressure damage to their skin which is indicative of good skin care. However we found a number of factors which could increase the risk of skin damage to people. Records we viewed did not tell us about incontinence aids or pad sizes which is important to know as the wrong size pad could lead to urine seepage and damage to the skin. Some people had air pressure mattresses and staff were not aware of individual settings. We accept this was something the district nurses had oversight of but staff should know what the setting should be. We were concerned that because there was poor oversight of people's weights we could not be assured that mattress settings were correct for people's needs. Some people were at risk of developing a breakdown to their skin. These people had specialist beds and mattresses to try and prevent this from happening. We also noted gaps in people's records which showed the frequency of repositioning. We were not assured people were repositioned as required. Regular repositioning helped to reduce the risk of pressure ulcers.

We noted one person on a pressure relieving mattress had crumpled sheets which would slightly reduce the effectiveness of the mattress in terms of protecting their skin. We noted another person elevating their legs by using their wheelchair rather than a stool or in a recliner chair. Lap belts were not used or considered for those active and in self-propelled or electric wheelchairs.

We identified some staff practice which could increase risks for people using the service. For example we saw areas of the service which were unclean and observed poor infection control practices. When staff were mopping and cleaning the communal floor, a hazard sign warned people of a wet floor. However, this was at a busy time of the day when people were mobilising and because of their cognitive impairment might not be as aware of the hazards. Another example was staff not following the company's accident policy or their training. We found staff had hoisted people following a fall before clearly being able to establish if they had an injury. There were circumstances where it was appropriate for staff to call 111 or for a more urgent response 999 and this was not always followed by staff. People's records did not give a full and complete picture about how people's needs were being met.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had not notified us in a timely way of incidents which affected the health, wellbeing or safety of people using the service. This meant we were not able to respond to incidents and use this information to determine if we need to inspect the service due to these risks. The service was not able to demonstrate they kept accurate records of incidents or took appropriate actions to manage the incident or accident effectively and try to prevent it from happening again.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration Regulations, 2009.)

On both days of our inspection the service had the number of staff it said it needed. There was a good skills mix, with newer staff working alongside more experienced staff. Agency staff were not used which meant people got continuity of care. We observed people mostly receiving timely care and supervision to help promote people's safety. Through our observation we felt staffing was sufficient in the morning but were concerned that later on in the day there were less staff to ensure people's needs were met and too few activities. Staff in the afternoon had to assist with non-care tasks which reduced the amount of time spend providing direct care to people.

We had a mixed response when we asked people and their relatives about their views of the staffing levels at the home. We spoke with one person who told us staffing levels were okay and they did not have to wait to have their care needs met. Another said "It's fairly good response to the call bell". Another person said, "I have had to wait because the staff are dealing with someone else, but they check that I'm okay waiting." One person told us "I'd like to get up more but at the moment they're a bit short-staffed." And a relative told us "We don't think there is enough staff all the time."

Staff said there were not always enough staff on duty and not all staff worked as a team. They gave the example of people living on the dementia care unit who sometimes required two staff to assist them. When staff were assisting in this way there were no staff member to support the rest of the people using the service. Staff said sometimes there were additional members of staff to help but not always. We observed throughout the day staff going for regular cigarette breaks. This reduced the number of staff on the floor and staff breaks were not planned around the needs of people using the service. We observed staff smoking outside fires escape rather than the designated smoking area. We also noted at busier times of the day such as lunch time there were no additional staff to assist people so some people had to wait for assistance. After 2.00 pm the staff were also responsible for serving the evening meal and clearing up afterwards which meant they had to balance this with providing care and supervision to people. On the day of our inspection the activities coordinator was on a day off then planned leave so staff were providing activities when they were not providing care. These meant activities were limited.

Following the inspection the manager provided us with a dependency tool they said they used to determine how many staffing hours they needed. This tool did not seem to take into account changes in people's needs or consider others factors such as if people were at high risk of falls so requiring closer supervision.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were domestic staff at the service to ensure high standards of cleanliness. People we spoke with were satisfied with the standards of cleanliness and most rooms we visited appeared clean and free of odours. One person told us, "A lady comes in everyday to clean my room. She's very good." Another said, "Yes, my room is clean and they know I'm fussy.

We viewed the service monthly infection control audits. The infection control audits were very

comprehensive, but did not identify a number of things we identified as part of our inspection. For example we found some areas of the service unclean such as the medication room floor, the laundry area and individual equipment such as a commode and wheelchair.

Following the inspection the manager produced audits including room check audits and wheelchair cleaning schedules which showed they were identifying issues but were not as robust as they could be. Flies were observed in one person's room whilst they were in there and in the kitchen whilst there was uncovered food and one person had complained about the flies. However, the level of cleanliness improved throughout the day.

Medicines were mostly managed safely and administered to people as the prescriber had intended. We reviewed people's medication administration records and saw missed signatures. However the correct numbers of tablets were in stock which meant staff were forgetting to sign the MAR sheet but people were receiving their medication. We viewed the homes medication audits and they had not identified the missing signatures and therefore had not taken any actions. The medication room had oxygen cylinders stored but there was no signage advising people of this and would put people at increased risk in the event of a fire. We found one of the medicine rooms had no facilities for staff to wash their hands. Staff told us they used the sluice room opposite.

During our inspection one person was complaining of pain repeatedly and was consistently told they had already had their pain relief. They were still in pain several days later and went to hospital with a possible infection which had not been identified by staff.

Staff administering medication told us they received training and were required to work through medication work books. Before administering medication staff had to observe and be observed to ensure they were competent to administer medication. One staff said this went on for about a week.

Staff were knowledgeable about how to raise concerns if they suspected a person to be at risk of harm or abuse. All staff had received training apart from the cook who had been in the service four months. There were policies and information telling staff who they should report concerns to, including external agencies. All staff said they felt able to report any concern and felt these would be dealt with. Staff knew who they could refer concerns to including external agencies.

The service had adequate recruitment processes in place to ensure only staff who had been sufficiently vetted were employed. This meant that new staff were only employed after a checkable work history was taken and they supplied at least two satisfactory references, proof of identification and place of address. They also checked that they did not have a criminal record which might make them unsuitable to work in care and to check they had not been barred. The disclosure and barring service has a register of people who are unsuitable to work in care. The manager is required to check and ensure any potential employees are not on the list.

Requires Improvement

Is the service effective?

Our findings

At the last inspection this area was rated as good. At this inspection we found the service did not adequately support people to eat and drink enough for their needs. We found records did not demonstrate people being offered regular snacks or high calorific food where people were at risk of unintentional weight loss.

We spoke with care staff, the cook and observed meal times. People were mostly positive about the food they received. One said, "The food's not too bad and there's enough of it." Another said "I can't eat eggs so they offer me an alternative." People had a choice of cereals for breakfast, but the cook said they could have a cooked breakfast if they asked. The menu for the day consisted of two options with the main meal at lunch and a light option in the evening. People were verbally offered a choice. We did not see any picture menus at the table to help promote people's choice. However the provider told us picture menus are available and used to show people when a new dish is being introduced on to the menu. Staff told us lunch was served at twelve but was late on the first day of inspection. It was served on one unit at 12.15 pm but the other unit waited until 12.45 pm .Some people were sitting at the table for twenty minutes we were told by choice. On the unit for people living with dementia when food was served staff did not explain what was on the plate. Neither did they show people alternative food plates so people could choose. Staff did not sit with people or provide much encouragement to eat. However most people appeared to enjoy their meal and there was little wastage. A number of people were in their rooms and staff assisted them with their meals. We noted a staff member standing beside a person rather than sitting next to them which did not help to promote their dignity. They had been identified at risk of aspiration and should be sat upright but we observed them slumped in the bed which could increase the risk of choking. In the main dining room in the residential unit there was a relaxed, social atmosphere.

There were people at risk of not eating or drinking enough and we found that the monitoring of this was poor. We asked the cook if they knew who was losing weight and they showed us a list of people's specific dietary requirements. They said they were fortifying foods so they had extra calories, such as adding cream to potatoes. However, from discussion with staff and looking at people's record's there was limited evidence that people were offered snacks, finger foods or home-made milkshakes. This would help people with smaller appetites to maintain their weight. The staff we spoke with told us no one was on weekly weights and no one had lost a significant amount of weight.

We looked at a sample of weight records and saw everyone was being weighed monthly regardless of risk and there were gaps of several months in some people's weight charts. Food/fluid charts were completed but these were not in sufficient detail as they did not refer to portion size but would state, 'Ate all' so we did not know how much a person had eaten. Where a person had refused a meal there was no record that an alternative had been offered or any snacks. People were going for long periods of time between meals from the evening until the next day. Tea was served around 5 pm and then there were no further entries until breakfast the next day.

On admission to the service a nutritional care plan was developed but we could not see how effective this was in identifying need because there was not an accurate, regular record of people's weights. One person

had been at the service for three months and there was only one weight record for them. We asked staff how they monitored peoples eating habits and dietary needs on admission and they said they recorded this as part of their daily notes. Notes were brief and did not demonstrate adequate monitoring.

Records were often contradictory. For example one person's dietary record said that this person enjoyed a varied diet, ate independently and their weight was stable and good. However, it later said that the person was referred to a dietician due to weight loss but no actions were recorded to show if they had been seen or what advice was given. We looked at their weight record and saw they had been weighed in March, May and July 2017 and each recorded a weight loss. There was no evidence to show how the service had tried to mitigate the risk. We raised concerns with the manager who did take immediate action to identify who should be weighed weekly. They also referred people to the dietician and the cook was intending to make homemade milkshakes to boost people's calories.

Fluid records were kept for those identified at risk of dehydration. The manager said 1000 ml's was the expected intake for most people. If people had 500ml's or less on three consecutive days, the computerised records would identify this up as red indicating risk. The manager said they had oversight of this and would raise poor fluid intake with the staff, or the GP. However the records we viewed were poor and did not always show people were getting adequate fluids and records were not always consistently kept. Information about how people were supported with adequate hydration was kept in different places giving an unclear picture of the person's total daily fluid intake. Staff spoken with were unclear about how much fluid people should have or actions to take if they were not drinking enough.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found records did not always fully document people's needs or how they were being met or changes identified. For example two people were nursed in bed and said to have upset stomachs. We could not see additional monitoring of these individuals and they were not routinely seen by the GP. The doctor's book showed who had been seen by the GP on their weekly visit but information was not always transferred into people's daily notes so there was not always a complete record. One person had been unwell and staff had rang the GP for advice, this advice was not added to their daily notes, they remained unwell and were taken to hospital for further investigation.

This is a breach of regulation 9 of The Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

In respect to other health care needs. A relative told us that they formed the impression that the doctor does not always come as quickly as they would like. Staff told us people regularly saw the optician and had access to the district nurse and chiropodist. However people and staff did not think there was a visiting dentist and a person with tooth ache had been seen by the GP. There was no guidance about promoting healthy mouth care.

Staff assessed and recorded people's capacity in relation to their care and welfare. People were offered choices but in a restrictive way. For example, staff made decisions for people in terms of when people had a bath or got up when they were not able to choose. Some people were able to decide for themselves what they did and were involved in deciding what their preferred routines and preferences were. Care plans including mental capacity assessments were seen but we saw some contradicting statements such as, 'has limited capacity' and then further entries stating 'no capacity.' It was difficult to see how staff acted in people's best interest when there was no clear determination of capacity or clear understanding of what

people could decide for themselves. The manager had made a number of Deprivation of Liberty safeguards. Four were pending and two had been approved.

Whilst at the service we saw the use of covert surveillance with cameras monitoring the communal areas. We requested the services policy to determine if the cameras were being used lawfully, and what the provider's primary reason was for the use of cameras. We also wanted to establish that the service had sufficiently consulted with people about the use of cameras and where people lacked capacity that the provider could demonstrate how the cameras were in their best interest. There was evidence of consultation with regards to the use of cameras but we could not determine if people had capacity to understand why the use of cameras was deemed as necessary and were not able to establish the primary reason for the cameras.

We found staff mostly had the necessary skills and competence for their role. We spoke with care staff, including senior staff, the manager and the cook. We found staff had varying levels of experience but all appeared competent and knowledgeable about people's needs. Staff told us that the training they received was good. They also told us that training was provided by the manager and undertaken in small groups, which they considered an effective way to learn. One staff recently employed had received no training for their current role. However, we were told that they had transferable skills and experience and their training was booked. We observed new staff shadowing existing staff. We were told that new staff did not work on their own until they felt confident and deemed as competent.

There were gaps in staff's knowledge. Not all staff had completed training relevant to the needs of people they were supporting or were able to demonstrate they had adequate knowledge. Additional training was being planned and rolled out to staff to ensure all staff had training in regards to people's individual's needs. Staff said they were regularly supported and had one to one supervisions, regular team meetings and an annual appraisal of their performance. This meant they had opportunity to discuss their professional development and any concerns they had about the work place.

Requires Improvement

Is the service caring?

Our findings

At the last inspection we rated this area as good. At this inspection we have rated it as requires improvement because we found the care was not provided to a consistent standard across the service or personalised to people's individual needs.

At this inspection we found information about people's lives, preferences and experiences was limited and we could not see how the provider took this into account when planning the service. There was limited information about people's preferences and choices and how they would like to receive their care. Staff told us memory boxes and life stories were in place once and were being developed again. Memory boxes are a place to keep things important to the person and help them reminisce. However staff knew people's needs and used this to enhance people's care. For example one person used to help their parents in their sweet shop. One of the carers knew the sweet shop and talked about this with the person helping them relive their experiences. This enhanced the person's wellbeing.

We observed both positive and negative interactions from staff which meant people did not always receive consistent levels of care. One person was concerned that when staff helped them some, not all, members of staff talked between themselves, excluding them. This person said: "I feel like saying 'excuse me, I'm here, don't ignore me." Some staff spoke about people in terms of their needs and wishes whilst other staff spoke about routines and tasks. Afternoon staff had more time to sit with people following lunch. In the morning staff were busy and although they regularly interacted with people these interactions were hurried and staff did not always give people time to process and respond to information. For example we observed staff standing on one side of the room asking people if they wanted a drink rather than going over to them and establishing eye contact and ensuring they had time to respond.

Staff did not always promote people's choice to engage in activities or help them maintain their independence and well- being. Staff asked: 'do you want a cup of tea or coffee' and at lunch, squash was offered. Sugars were added to hot drinks based on people's previous preferences and a tin of biscuits were taken around. Meal selection was from two main options and the picture menu in the hall way was of little value to people as it did not reflect the day's menu. We felt it would be good if staff still asked people as their preferences could change from day to day. At lunch time people were given a choice of either, or from the set menu. People selected their option earlier in the day but were not shown picture menus to help them select their choice. This might have been helpful when considering people's level of cognition. At lunch time meals were served according to people's choice but staff did not explain to people what they had chosen or give them the option to change their mind.

People were mostly sat with the television on or music and we did not see much opportunity for people to participate in anything else. Some people had other activities they were engaged in such as reading the newspaper and playing cards.

The home was comfortably furnished and mostly suitable for people's needs. However one person told us, "My room is really small with very little space between my bed and my wardrobe and I struggle to get

around." This was for a person who needed staff assistance with transfers. Staff confirmed people did not have keys to their room which would have offered them additional privacy. The manager has subsequently told us that risk assessments would be completed to assess if people who wanted keys could hold them safely. We noted internal doors banging and there was an issue with automatic door closers which had the potential to disturb people when asleep.

Staff promoted people's dignity when offering personal care which was provided discreetly. We were concerned that where people were in bed, doors were left open and this meant people did not have privacy. The manager said this was people's choice and stopped people becoming too isolated. We could not see from people's records that they had requested to have their doors open. People confirmed staff treated them with compassion and dignity. One person said "Oh yes, very much so. They certainly treat me with dignity."

Staff told us 'relative and /resident meetings' were held but there was limited take up of these. One person told us "If there's anything to be changed they will discuss it with me." We saw resident feedback sheets which took into account people's experiences but did not always show what actions had been taken as a result of their feedback. There were quality assurance surveys which asked people set questions about living at the service but this was not appropriate for some people who could not tell us about their experiences. The survey results were not inclusive as they did not involve everyone's views of people using the service and feedback forms were not used as regularly as the service had intended. We discussed this with the manager who told us they had tried to schedule resident meetings at different times of the day to help ensure those who wanted to attend could. They said the cook was going to spend time with people to establish what they wanted on the menu. The manager told us how they met the cultural needs of one person and how a number of people at the service were vegetarian and their dietary preferences were taking into account when planning their meals. They also said the staff discussed people's needs with them when they were reviewing the plans of care.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we rated this outcome as requires improvement. This was because we found the programme of planned and spontaneous activities was limited. At this inspection we observed some activity was taking place but most of these were self- directed rather than being organised by the service.

The activities coordinator was off both days of our inspection and their hours had not been covered. The manager told us the activity coordinator worked 25 hours a week but this was going to increase to full time. In studying the rotas we found the activities co coordinator had a varied shift pattern which did not amount to 100 hours a month but considerably less. We were concerned that 25 hours was not sufficient to offer everyone regular opportunity to engage in planned activities based around their assessed needs. We asked people about activities and got a mixed response. One person told us, "I read, knit, do crochet and I can sit on the bed and watch television and I'm happy here in my room." Another said "I spend my time in the lounge and I have no hobbies. I am not aware of any organised activities." A relative told us they had not seen organised activities. We asked people if staff had time to sit and chat. One person said, "Yes, the staff will just sit and talk if they have the time." Another said staff did not have time.

We observed staff offering to change the television channel, putting music on for people, and spending time chatting to people. In the residential lounge we observed a number of visitors and people relaxing to watch the tennis. Chairs were arranged in such a way that the television was visible to all those watching it. People told us they did arts and crafts, had entertainers and had fetes and barbeques in the summer. One person told us staff helped them stay mobile and they did bowling and catching a ball. They said staff spent time with them but wished there were more people to talk to. Staff said a volunteer was starting at the service soon and they occasionally had visits from school children such at Christmas. No one went to church but the local vicar came in at their request. The activities coordinator had a diary in which they recorded any planned events but this was not available on the day of our inspection. Some people's daily notes provided limited evidence of how their social needs were met according to their needs.

We found staff were mostly responsive to people's needs. However we did observe times when people had to wait. For example, while we were talking to the relatives in the presence of a person using the service, they said they needed to be taken to the toilet. One of the relatives told a member of staff who said that they would be back in a minute. Other staff walked past and staff needed to be reminded this persons request was urgent before they assisted the person. We observed staff member playing cards with a person when they got called away and they said to the person, "I will be back in a moment." but they did not come back.

The manager told us people had a choice about when to get up and when to go to bed and this was recorded in people's care records. However, we did not get this message consistently from staff, some staff said it was of the persons choosing whilst others said 'night staff get most people up.' Staff said baths and showers were mostly done in the afternoon because it was quieter rather than according to people's preferences. People were offered drinks throughout the day. We asked people how their preferences were met in terms of the delivery of care. One person told us "I don't need any help so I can choose what time to get up and go to bed." Another said, "I'm ready to get up when the noise of the staff talking in the corridor

wakes me up. It seems to be about 6 o'clock." Another said, "I don't really choose what time to get up but I do choose what time to go to bed."

We noted one person in a hospital bed they had not been assessed for told us the bed was uncomfortable. We asked the manager about why they were in this bed and they said, '"It is what they had got." Peoples care preferences were recorded in care plans but not in sufficient depth of how staff should promote people's preferred night time and morning routines which might help in terms of reducing people's anxiety such as how many pillows they liked, door closed or open and if they liked the radio on. Records were not sufficiently personalised which meant we could not assure people would get continuity of care. Care plans about promoting continence did not give enough detail such as pad size. Manual handling plans did not include type of hoist or sling size. There was limited guidance to help staff understand what equipment should be used. We found information was sometimes contradictory. However staff were sufficiently knowledgeable about people's needs.

People spoken with were not aware of their plan of care. One said "I've never seen a care plan." Another said "I haven't seen a care plan and I didn't know there is one." However we accept people might not be aware of their care plans by the fact they were held as an electronic record and not accessible to people unless printed off. Each unit had a tablet computer that staff recorded in every day, to show what care people had received. The tablet computer included care plans and risk assessments. The daily notes had limited detail and did not demonstrate how people's care was personalised around their individual needs. There was information about health care conditions, and illnesses people had but no information about how this impacted on the person. For example one person had Parkinson's disease but their care plan did not say how this affected their mobility or their self-help skills. The manager told us the person with a diagnosis of Parkinson's/dementia had no symptoms and this did not impact on their daily living skills so we would question why they were in a locked dementia unit and why their care plan referred to the diagnosis. Some people had dementia but there was nothing about the type of dementia, the stage of dementia or how it impacted on people daily living skills.

Nutritional care plans and risk assessments included generic statements which were not personalised to the person's individual needs or giving specific instruction. We noted people were on two hourly checks at night without any real evaluation of the person's specific needs and risks which might require less or more observation to keep people safe, hydrated and comfortable.

The service had an established complaints procedure and there was opportunity for relatives to have their say about the care provided. We asked people if they were unhappy with the care what they would do. One said, "I would talk to one of the carers, they're so good." Another said, "I've never had to complain but if I had to I would go to the manager." People were aware of the complaints procedure and happy to raise concerns if they had any.

We found relative meetings were held but were not well attended. We were not provided with any additional evidence of how the manager had tried to encourage regular communication with relatives such as by holding drop in sessions, having a resident of the day, or sending out electronic agendas, forthcoming meeting dates or running a newsletter.

Inadequate

Is the service well-led?

Our findings

At the last inspection we identified this outcome as requires improvement because the service had failed to display their previous inspection rating which is a breach of regulation. At this inspection they were displaying their rating. However at this inspection we identified lots of concerns and breaches of regulation which helped us to conclude this is not a well-managed service.

Although staff spoken with told us they found the manager and other senior staff supportive and approachable. Some staff indicated that not all staff pulled their weight on shift which meant people did not receive consistent and timely care across the shift and we also noted differences between staff attitude and approach. The manager was available and present during both days of the inspection and acted on our feedback to reduce immediate risks to people using the service. They addressed some of our fire safety concerns and concerns about how they monitored unintentional weight loss. Following the inspection we wrote to the provider asking for reassurances of how they managed falls and ensured staff followed any service specific guidance. We also asked for assurances with regards to bedrail safety. The provider responded within the timescale we requested.

It was not always clear how the manager took into account feedback about the service and used the information to improve the service. For example we viewed complaints since the last inspection. These included four from other professionals and three from families. All had been responded to within the given timescales. However we were unable to see how feedback was used to inform service improvements or an openness and willingness to view complaints in a positive way.

We could not be assured of the effectiveness of the current management arrangements. The registered manager was overseeing two care homes and spent equal amounts of time at each. The other service was recently rated by CQC as inadequate and had not until recently had a registered manager, although one had now been appointed.

In the managers absence at Victoria Hall the service was overseen by the deputy manager or senior carer. We had concerns that none of the senior staff or manager was able to accurately tell us about the immediate risks to people care, welfare and safety. We found information governance poor and the dissemination of information across shifts ineffective. The manager said they used to have written handovers and this had worked well so it was difficult to see why this was no longer used.

Staff expressed concern about the use of the tablet computer saying on occasion they stopped working, the longest time being a week. They said information had not always been backed up and had been lost. The manager said this had been resolved but we gathered evidence to the contrary. Staff told us sometimes they were unable to record information electronically because the system was down. On these occasions they said they kept handwritten notes which were uplifted to the electronic record when it was working. This might not necessarily be on the same day and might be added by a member of staff who did not provide the care. We were concerned that this could increase the risk for errors. We saw examples of where essential information had not been included on people's daily notes such as GP visits. We looked at accident records

which recorded falls but these had not been added to people's daily notes. For example one person had five accident records all relating to falls in the last six months but when we checked their daily notes only two were recorded. This meant when the team leader or senior reviewed the person's care plan they did not have a full picture of the person's needs or risks. This meant people's care records did not reflect changed or unmet needs or risks.

In addition to electronic records staff used diaries, communication books, and a doctor's book. Room records were used to record when staff checked or repositioned people and to record food or fluid intake and monitor people's continence needs. These records were not always transferred to the electronic record so unless staff looked at all the available records it was difficult to piece together any changes to a person's needs or how staff were monitoring people's needs. For example we were told about a person who had a series of falls but not all the staff including the manager were aware of this. An accident record had been completed but information had not been transferred to their notes or handover record. These meant actions had not been taken to try and prevent additional falls or to establish the cause of the fall such as a change of medication, possible infection, or dehydration which if identified could help prevent further falls.

Staff were not able to find information on request and were not always using the right documentation. For example accidents/incidents were sometimes recorded on blank bits of paper. On reviewing accidents these were not in date order and information was sometimes in the wrong place and did show what had been done as a result of an incident/accident. We reviewed service audits carried out three monthly by the Compliance & Monitoring Officer. One was completed in January the other in April 2017. These did not identify actions identified as part of our inspection. They also did not include the views of people using the service, in the first audit only the manager and cook were spoken with. In the second audit one person was spoken with and one staff member. The report stated CQC were notified on any incidents affecting people's safety, however the serious injury which had occurred eight days before had not been notified. It stated bedrails were maintained but our review of records showed two bedrails had been broken for a period of time.

We were unable to see how duties were effectively delegated on shift as care staff did not have specific areas of responsibly for key areas of practice. Senior staff had oversight of care plans and care plan reviews and staff knew people well. However communication across shifts was poor. We observed staff going for regular breaks. Breaks were not organised in a way which ensured the continued safety of people using the service.

Some people were not able to tell us who the manager was and the availability of the manager was raised as a concern. We were unable to see from the rotas when the manager was at the service and how regularly they supported and supervised staff. We were also not assured how people and their relatives would know when the manager was going to be at the service.

One relative raised concerns about their family member's health and said they had been seen by the GP but they had been unable to get any feedback and had not been informed of the outcome of the visit. They said when they rang the manager was not available. The second concern raised with us was from a relative stating they could not always get in touch with their family member by phone and information was not always relayed about their needs. It was not clear how complaints were dealt with in the absence of the manager.

There was not sufficient oversight of the health and safety of people that used the service. People's needs were not kept under sufficient or regular review and notes were not comprehensive or recorded in a timely fashion. Staff were not responding quickly enough to people's changing needs or taking appropriate actions

to reduce the risks to people's safety. Quality assurance systems were poorly developed. On the first day of inspection we were not provided with information showing us that the manager had an overview of risk in relation to falls/incident or accidents but later produced a log which they sent to head office for analysis. This log showed repeated incidents and accidents and did not assure us actions were timely or proportionate to the risk.

A system of audits to help the manager identify if the care provided was appropriate was poorly developed. Following the inspection we were given a series of weekly dining room audits but these were limited in scope and did not include the views of people using the service. This would help assess the quality of care which most people could not tell us about. There were no dining room audits or general observations.) We identified issues that had become standard practice and did not reflect a responsive, individualised service. For example we noted people had cold drinks served in plastic cups and hot drinks were served in a cup but people were not offered a saucer or mug. The manager said saucers were not provided because people had poor manual dexterity but this had not been assessed on an individual basis.

The above supports a breach of Regulation 17. Good Governance. (Regulated Activities) Regulation 2014.

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 18 Registration Regulations 2009 Notifications of other incidents The service failed to notify us of significant incidents in a timely way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The service was not able to demonstrate through its records and staff understanding of how they provided individualised care based on the accurate assessment of people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person was not fully assessing the risk to the health and safety of people using the service. We were not assured that all reasonably practical action to mitigate risk was being taken.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not being adequately supported to have enough to eat and drink and there was poor monitoring of this.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not sufficiently robust and were not identifying areas requiring improvement. The service was unable to identify how it was assessing, monitoring and taking action to reduce risk in relation to people's health,

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service was not able to demonstrate that they had sufficient numbers of staffing at all times to ensure people's physical and social needs were adequately met.