Venetian Healthcare Limited

Victoria House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 16 and 21 June 2016 and was unannounced. The home provides accommodation for up to 22 people including people on short-term respite stays. There were 18 people living at the home when we visited. All but one were older people with physical frailties. The home was based on three floors connected by a passenger lift; there was a choice of communal spaces where people were able to socialise; most bedrooms had en-suite facilities.

There was a registered manager in place. 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.

We found people's safety was compromised in some areas. Not all ancillary staff had received safeguarding training, although this was being rolled out. The registered manager had dealt appropriately with an allegation of abuse, although they had not made a record of the incident.

Appropriate recruitments checks were made, but were not always reviewed before staff were employed to help make sure they were suitable to support people living at Victoria House.

Risks to people were not always managed effectively. Staff were not clear, and there was a lack of information, about how to protect people from the risk of pressure injuries. Assessments of the risks posed by bedrails or stairways, and the fire risk posed by a person who smoked, had not been completed.

Not all staff had received practical training to enable them to support people to move safely. Staff had not been trained to calculate the body mass of people who could not use weighing scales.

The provider had not notified CQC of a serious injury to a person, as required. The registered manager had not followed the provider's policy by giving the person, or their relative, written information about the incident.

Quality assurance systems were in place but not always effective. They had not ensured that improvements were identified and made promptly.

Staff did not always follow legislation designed to protect people's rights and ensure they were only supported with their consent.

People received a choice of suitably nutritious meals. However, the amount people drank was not recorded in a way that allowed staff to assess whether people had drunk enough.

Staff knew and met the needs of most people well, although care plans did not always support the delivery of personalised care as they lacked information.

Medicines were managed safely, although storage facilities did not always meet the required specifications and there was a lack of information about an 'as required' medicine for one person.

People were encouraged to make choices about how and where they spent their time. They had access to a range of activities, which were being developed further. Staff sought and acted on feedback from people and there was an appropriate complaints procedure in place.

There were enough staff deployed to meet people's needs. People were supported to access healthcare services when needed. There were suitable arrangements on place to deal with foreseeable emergencies, such as a fire.

People were treated with kindness and compassion by staff who knew them well. Staff showed concern for people's well-being and involved them in planning the care and support they received. People's privacy was protected at all times.

Staff described the management as "supportive". They were clear about their roles and motivated to develop the service for the benefit of people. They were supported in their work through appropriate induction and supervision.

We identified breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken 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?

Requires Improvement

The service was not always safe.

The process used to recruit staff was not robust and did not always ensure that staff were suitable to support people living at the home.

The risk of people developing pressure injuries was not managed effectively and put people and staff at risk of harm. Most other risks were assessed and managed appropriately. However, risks posed by external stairways and the fire risk posed by a person who smoked had not been assessed.

Medicines were managed safely, although further information was needed about the use of an 'as required' medicine and some storage arrangements did not meet required specifications.

Care staff had received safeguarding training, but this had not been delivered to all ancillary staff. Some staff were not clear about how to identify and report abuse.

There were enough staff deployed to meet people's needs. Suitable arrangements were in place to deal with foreseeable emergencies.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always follow legislation designed to protect people's rights or ensure they were acting with the consent of people.

Staff were not suitably trained to deliver care and support in a safe and appropriate way. However, with the exception of night staff, most received appropriate support, induction and supervision.

People praised the quality and variety of the food and were offered a choice of drinks throughout the day. However, the fluid intake of people at risk of dehydration was not recorded in a

meaningful way.

People were supported to access healthcare services when needed.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion by staff who knew them well. Their privacy was protected at all times and they were shown respect.

People were involved in discussing the care and support they received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Most people received personalised care and support. However, staff were not clear about how to meet the needs of one person.

Care plans lacked information and did not support the delivery of personalised care.

People were encouraged to make choices about aspects of their lives, including how and where they spent their time. They had access to a range of activities, including animals which visited from a local project.

Staff sought and acted on feedback from people. There was an appropriate complaints policy in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

CQC were not always notified of significant events and the provider's duty of candour policy was not always followed by staff.

Quality assurance systems were not always effective and did not always ensure that action was taken to maintain standards.

People enjoyed living at Victoria House and felt it was organised well.

Staff described the registered manager as "supportive". They

were motivated and showed a strong desire to improve the service for the benefit of people.

Victoria House

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 inspection took place on 16 and 21 June 2016 and was unannounced. It was conducted by two inspectors. Before the inspection we reviewed previous inspection reports and notifications we had been sent by the provider. A notification is information about important events which the service is required to send us by law.

We spoke with nine people living at the home. We also spoke with the registered manager, the deputy manager, the care coordinator, five care staff, the chef and a cleaner. Following the inspection we spoke with a community nurse who often visited the home.

We looked at care plans and associated records for eight people and records relating to the management of the service. These included staff duty records, staff training and recruitment files, records of complaints, accidents and incidents, and quality assurance records. We also observed care and support being delivered in communal areas.

The home was last inspected on 10 March 2014, when we identified no concerns.

Requires Improvement

Our findings

Staff recruitment procedures were not robust and did not ensure that only suitable staff were employed. We viewed three staff files for staff who had been recruited in the past year. Each contained an 'adult first' check from the Disclosure and Barring Service (DBS). These checks are made to see whether the applicants are on a list of people barred from working with vulnerable adults. In addition to these checks, providers are required to complete enhanced DBS checks to establish whether applicants have any relevant criminal convictions to help them make informed decisions about the staff they employ. We found applications for the enhanced checks had been made, but the registered manager was unable to confirm whether they had been seen or reviewed prior to the staff members starting work at the home. Where applicants had declared that they had police records the provider had not documented why they felt these applicants were suitable to work at Victoria House. Neither had they completed risk assessments to consider the risks they may have posed to people. Written references had been obtained from previous employers, although a reference for one person had only been given verbally and had not been recorded.

The failure to operate effective recruitment procedures to ensure staff were of good character was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Individual risks to people were not always managed effectively. For example, clear guidance was not available about how staff should protect people from the risk of skin breakdown. One person was being cared for in bed, which could put them at risk of developing pressure injuries, but an assessment of this risk had not been completed and measures to mitigate the risk had not been identified or implemented. Two staff members told us they would "keep an eye" on the person's skin condition and would contact the community nurses for support if they developed a pressure injury. However, there was no information available to advise staff about how to prevent injuries from developing, such as supporting the person to change position regularly in bed. Between the two inspection days, staff sought advice from a community nurse and we were shown the community nursing care plan for the person. However, this information had not been used to develop a plan which the care staff at the home could use to support the person appropriately.

Staff told us that when the person slid towards the bottom of the bed, they pulled the person back up using the bed sheet as they did not have access to a 'slide sheet' of the right size. A slide sheet is a piece of equipment made of slippery material which is designed to assist staff to move people with a minimum amount of effort. It reduces the likelihood of damaging the person's skin or causing upper body injuries to staff. The lack of appropriate equipment to move the person safely put the person and staff at risk of harm.

Three people had been given special pressure-relieving mattresses to help prevent the development of pressure injuries. However, one of these was not set correctly, according to the person's weight, so may not have worked effectively; and there was no process in place to help make sure the mattresses remained on the correct settings. Bedrails were being used to prevent two people from falling out of bed, but assessments of the risks they posed had not been completed.

The failure to ensure care and support were always delivered in a safe way and people were protected from avoidable harm was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home was based on three floors. External fire escapes led from exits on the first and second floors down flights of stairs to ground level. These doors were not alarmed, so staff would not be aware if people exited the building through them. The mobility of most people living at the home was limited and some experienced episodes of confusion. This could put them at risk of falling if they tried to negotiate the fire escapes without staff support. The registered manager told us they used pressure mats in the rooms of people on upper floors who would be at risk if they accessed these stairways, so staff would be alerted if they left their rooms. However, the arrangements were not robust and the registered manager agreed to review the safety of these exits. One person smoked cigarettes, but an assessment of the fire risks they posed to themselves and others had not been completed. Following the inspection, the registered manager completed a smoking risk assessment for the person, which they sent to us.

Assessments had been conducted of the risks of people falling and measures had been put in place to mitigate the risk. For example, staff made sure people used mobility aids appropriately and were always accessible. However, there was no process in place to analyse falls across the home, in order to identify patterns, such as common times or places where people fell, so that measures could be put in place to reduce the frequency of people falling. We discussed this with the manager, who agreed to implement a system to do this.

Some people were supported to take appropriate risks that helped them retain their independence and avoid unnecessary restrictions. For example, a person in a bedroom on the top floor of the home was at risk it they used the stairs without staff support. They had been offered a ground floor room but had chosen to remain where they were. They were aware of the potential risks and, to help mitigate them, staff had placed a notice on the inside of the person's door reminding them to summon staff to support them to leave their room. Another person wished to use the kitchen to make drinks, so an agreement had been reached for them to do this at times when the kitchen was not being used by others. This allowed them to make early morning drinks, which they told us they enjoyed doing.

Suitable arrangements were in place for the ordering, storing, administering and disposing of most medicines. Medicines were administered by staff who had been suitably trained and assessed as competent to administer them. Medication Administration Records (MAR) were used to record the administration of all medicines and were signed by staff to confirm they had been given as prescribed and at the required time. With the exception of two entries that had not been signed by staff, the MAR charts had been completed fully. We conducted random checks of five medicines and found all were properly accounted for and had been given as directed. A clear system was in place to monitor the use of topical creams to help make sure they were not used beyond their 'use by' date. One person self-administered some of their medicines; a risk assessment had been completed, showing they were able to do this safely, and they had access to secure storage for their medicines.

Information about when staff should administer 'as required' (PRN) medicines, such as pain relief, had been

developed to help make sure people received these consistently. One person said, "If I had a headache, I'd ring the bell and they'd give me something." However, information about one person's PRN sedative did not provide sufficient information about when it should be given, or other strategies that could be used to support the person when they became anxious, which might avoid the need for giving it. Some medicines are subject to additional controls by law. These should be stored in a cabinet built and installed to specified standards. We viewed the cabinet that was being used to store these medicines and found it did not meet the required specifications. The registered manager told us this had also been identified during a recent visit by a community pharmacist. They said they were looking at ways to upgrade the cabinet and also agreed to review the information about when to administer PRN sedatives to people.

People said they felt safe living at Victoria House. One person told us, "Nothing worries me. It's quite safe here." Another person said, "There's nothing that frightens or worries me here. I feel safe enough."

Most staff had received safeguarding training and were aware of people who were at particular risk of abuse. However, training for non-care staff, such as kitchen staff and cleaners had only just started to be undertaken. When we spoke with these staff, some were not aware of their responsibilities for safeguarding people. Two care staff members told us they had reported incidents of concern, about the way a colleague had interacted with a person, to the registered manager. One of them said the registered manager had spoken to the person concerned. The registered manager told us they had investigated the incident and were satisfied that the person had not been abused. They had not made a record of the concern or of their investigation, but undertook to do so.

People said they were supported by sufficient staff to meet their individual needs. One person said, "[Staff] always come quickly when I press my buzzer." Another person told us staff "usually come quickly" when needed. Two people needed the support of two staff members to mobilise and confirmed two staff always attended to them. Some medicines needed to be given before breakfast, so a staff member started their shift at 7:00am each day in order to administer the early medicines. The registered manager told us the staffing levels were based on people's needs. They said, "If I told the owners we needed [more staff] they would be fine. For example, we used to have a twilight shift when we had a person who [used to become unsettled in the evening]."

There were arrangements in place to keep people safe in an emergency; staff understood these and knew where to access the information. Personal evacuation plans were available for all people and they included details of the support each person would need if they had to be evacuated, such as in the event of a fire. The fire safety systems were tested weekly and two fire drills had been conducted since the beginning of the year.

Requires Improvement

Our findings

Staff did not always follow the principles of the Mental Capacity Act, 2005 (MCA) and its code of practice. The 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 Act 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. Most people living at the home had full capacity to make day to day decisions and some had signed their care plans indicating their agreement to the care and support planned.

However, the care records for two people showed they may not have been able to make decisions about aspects of the care and support they received. For example, pressure mats had been put in place to monitor the movements of a person. A staff member told us the reason for this was because "[the person] is wandering everywhere and we like to know where she is going." When we spoke with the person, they were unable to tell us why the mats were in place. There was no record to show they had agreed to their use and staff had not assessed the person's ability to make decisions about them. Therefore, staff were unable to show why the monitoring mats were in the person's best interests. Another person had limited verbal communication and fluctuating capacity to make decisions. Staff were using bedrails to stop them falling out of bed, but had not sought the person's agreement to their use, nor assessed their ability to make this decision. A staff member told us, "[The person] wouldn't comprehend what we are trying to do with him. For example, he has medicine to help his mood, but I'm not sure he knows why he is taking it." Although they doubted the person's ability to consent to receive medicines, they had not undertaken an assessment of their ability to do this.

Bedrails were also being used for a further person, who had capacity to make all their own decisions. When we spoke with the person, they banged on the bedrails with their fist and made it clear that they did not want them in position and had not agreed to their use. Staff told us the bedrails were used "because they came with the [hospital] bed, so we thought we had to use them". This showed a lack of understanding as the bedrails could be left in the lowered position. The registered manager spoke with the person and it was agreed that the bedrails would be lowered during the day and only used at night, which the person was happy with.

The failure to ensure that care and support were only provided with the consent of the relevant person was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not all staff were up to date with their essential training. Training to support people to move and re-position safely comprised of two parts. Most staff had completed the theory part using an online training tool. However, not all staff had completed the second part, which was a practical session where specific techniques were demonstrated and practised. These staff were not familiar with appropriate techniques. For example, one staff member described how they supported a person to transfer from their bed to a chair by lifting the person under their armpits. When we spoke with the person, they confirmed that staff used this technique. The technique described was not an approved method of supporting a person to transfer and risked causing injury to the person and the staff member. The staff member told us, "I sometimes don't feel safe [moving some people]. I have to take chances which I don't like doing. I asked for training about three months ago, but it hasn't happened yet." Other care staff were not clear about the correct techniques to use to support another person to reposition in bed. Some said they had no difficulty turning the person, while others said they found it "really hard". One staff member said, "The training I did covered the use of equipment, but didn't cover turning [the person].

The provider's policy, and best practice, required staff to refresh the practical element of their moving and handling training every year. Records showed that only one member of staff was up to date with this training. The registered manager told us they were no longer using a training company that used to provide this training, and had yet to appoint an alternative training provider.

In order to monitor people's weights, staff weighed most people using a weighing chair. However, one person was not able to use the weighing chair, so had not been weighed since January 2016. No staff member had been trained to calculate the body mass index (BMI) of people who could not be weighed. The inability of staff to monitor people's weight or body mass put people at risk of undiagnosed weight loss.

An ancillary worker gave us a list of training that they had yet to complete. They said, "I have to do it online, but I haven't got a computer at home. I think I can do it at work, but I don't have time." The registered manager told us they were waiting for a laptop computer to be set up, so staff would be able to complete the training while at work. They accepted that some staff had not started to undertake any of their online training yet.

The failure to ensure staff were suitably trained was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although we identified concerns in the way some people were supported, other, more independent people said they were satisfied with the care and support they received. One person told us, "I very much like living here. The staff are all very good." Another person said, "I like living here very much. I get well looked after. It's ideal for me."

New staff completed a period of induction, during which they worked with experienced staff to get to know people and how to meet their needs. The time spent working with other staff was based on the needs and experience of the staff member, but varied from one to four weeks. A new staff member told us, "I had a great person that I shadowed. There was a 'tick sheet' we had to cover until I could do everything." The registered manager was aware of the need for staff new to care to complete the Care Certificate. They had made arrangements for staff to achieve this through a mixture of online training and on the job training. The Care Certificate is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people.

Staff were supported appropriately in their role, felt valued and received regular supervisions. Supervisions provide an opportunity for managers to meet with staff, feedback on their performance, identify any

concerns, offer support, and discuss training needs. Staff supervisions included observations of their practice to assess their competence. The registered manager told us the frequency of supervisions depended on each individual. Some staff, who were new to the role, had them monthly, while more experienced staff had them four times a year. A staff member told us, "I have supervisions to see how I'm doing. If I don't feel comfortable with anything I've done, I can raise it." Records showed night staff had not received any supervisions since the start of 2016, which the registered manager told us they were seeking to address. Dates had been set for staff who had worked at the home for more than a year to receive an annual appraisal to assess their performance.

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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider was following the necessary requirements. No DoLS authorisations were in place, but the registered manager was clear about the process of applying for them should they be needed.

People were offered a variety of nutritious meals appropriate to the seasons, including cooked breakfasts daily. Alternatives were offered if people did not like the menu options of the day. A choice of drinks was available throughout the day and staff prompted people to drink often. One person needed support to eat some of their meals and they received this in a dignified way.
Kitchen staff were clear about the people who needed special diets and presented these in an appetising way.

People praised the quality and variety of food. One person said, "The food is very nice. They give us a choice, like salad, or fish or a roast. I get plenty of water. If I wanted squash I would get a choice and have cups of tea and coffee whenever I want." Another person told us, "I can always ask for something special; I like a bit of stilton [cheese] at teatimes and they've got me some for today. You just ask any of the carers and they get it." People told us they could choose where to take their meals. Some took them in their room, some in the dining room and some in the lounge.

People's food and fluid intake were recorded. However, staff were not clear whether they needed to do this for everyone or only for those people who were at risk of malnutrition or dehydration. We looked at the fluid intake records for a person who had been identified as at risk of dehydration and found they were not recorded in an appropriate way. There was no target amount listed to inform staff how much the person should be encouraged to drink; the type of drink was recorded, such as hot chocolate or tea, but not the quantities; and the amount the person drank each day was not totalled to assess whether they had drunk enough. We discussed this with the registered manager, who agreed to review the way fluid intake was recorded.

People were supported to access other healthcare services when needed. Records confirmed that people were seen regularly by doctors, nurses and healthcare specialists. One person had a telephone in their room and chose to make their own appointments, while appointments for other people were made by staff. One person said, "I go to the diabetic clinic and the nurse comes to take blood sometimes. The doctor came to see me on Monday as I had a bad throat and I've now got some antibiotics for it." A community nurse who had regular contact with the home told us staff sought and acted on their advice.

Good

Our findings

People were treated with kindness and compassion in their day-to-day care. Staff were described as "good", "friendly" and "caring". One person told us, "The carers are lovely, I wouldn't go anywhere else." Another person said of the staff, "They treat me well. There's an atmosphere of caring. I was told [when I arrived] I could do as I liked as this was my home, and that has carried on."

All the interactions we observed between people and staff were positive and it was clear that staff knew people well. Staff used their knowledge of people to strike up meaningful conversations and build relationships. For example, we heard conversations about the dogs people had owned and staff sometimes brought their dogs for people to meet and stroke. Some people enjoyed banter with staff and we heard them teasing each other in a gentle way. One person stuck their tongue out at a staff member who responded in a humorous way by saying, "Don't stick your tongue out at me, you're not too old to be put over my knee." The person was nearly 100 and burst out laughing. Another person appeared bored, so was invited into the office to spend time with staff. The staff member said, "Why don't you come in here for a change of view and some different company?" They then had a positive conversation about the person's earlier life and occupation.

Staff showed concern for people's well-being. One staff member said, "I get upset when people say they're depressed. I tell the manager and we keep an eye on them. She sits and has a cup of tea and a chat with them and then they're right as rain." Another staff member told us, "I treat residents as I would want a member of my family treated; with dignity and respect." Staff used touch appropriately to reassure people and people often sought and received hugs from staff members who they felt close to.

The registered manager promoted the involvement of people in planning the care and support they received. They had changed the storage arrangements for medicines to make them more accessible to people and encourage them to manage their own medicines. Parts of people's care plans, which needed to be accessed daily by staff, were kept in people's rooms, so people would be aware of them and feel able to contribute to them. One person told us they liked reading their care plan and the records staff had made about the care they had received.

Staff had designated 'talk time' with each person where they spent time talking about the care and support they received and any changes they wished to make. Records were made of discussions and we saw people had been able to influence the way they were cared for. For example, during one person's talk time, they requested a nightlight and this had been provided.

People's privacy was protected at all times. Before entering people's rooms, staff knocked, waited for a response and sought permission from the person before going in. Staff also treated people with dignity and respect. They described practical steps they took when delivering personal care, such as closing curtains and doors, and keeping the person covered as much as possible. 'Do not disturb' signs were used on the outside of people's doors when they were receiving personal care or did not wish to be interrupted.

One person was supported to follow their faith. Their room was decorated with religious artefacts and prayers and they were offered the opportunity to see their minister of religion when they visited the home.

Requires Improvement

Our findings

Most people told us they needed minimal support from staff. They were independently mobile, could deliver much of their personal care themselves, could express their wishes and were able to eat independently. They just needed help with dressing and bathing, together with some occasional prompting, for example to remind them to use their walking aids appropriately and to make sure they did not put themselves in danger. Staff knew and met the needs of these people well. They were led by people's wishes and preferences and delivered support in a personalised way that suited and satisfied each person.

When we spoke with staff, they demonstrated a good awareness of people's individual support needs and how they preferred to receive care and support. For example, they knew how often people liked to bathe, whether they preferred a bath or a shower, and what support (if any) they needed to dress; they knew what medicines people were taking and how they liked to receive them; they understood people's individual dietary needs and where people liked to take their meals. One person described the way they preferred to be supported with personal care and then said, "[Staff] know how to help me in the way I like."

However, care plans did not always support the delivery of personalised care. Staff told us the care plans were being developed into a new format to make them more individualised. However, they accepted that further work was needed as they provided a summary of people's needs, but did not provide sufficient information about how each person's needs should be met. For example, they specified the number of staff needed to support each person to bathe, but did not detail what the staff needed to do to or the way the person preferred to receive personal care. Continence care plans specified the need for continence products to be used, but did not specify how and when they should be used to support the person's continence needs. This was particularly relevant for one person, whose needs were more complex. For this person, we found staff were not consistent in their approach and did not have a clear understanding of the person's needs and how they should be met. Between the two days of the inspection, staff sought advice from the community nursing service about how to meet the person's needs. On the second day of the inspection, we found staff were clearer about this and were developing a care plan to help ensure all staff followed an appropriate and consistent plan. The registered manager told us they had recognised that the needs of this person had increased and had been in discussions with the person and their family about the possibility of them moving to a service better suited to meet their needs.

Another person had become unwell between the two days of the inspection and their mobility had decreased significantly. Staff responded promptly by referring the person to their GP and taking advise from the 'crisis team' who attended. The crisis team provided advice and additional equipment to help staff

support the person effectively. They also arranged for the person to be assessed by a continence specialist.

People were supported and encouraged to make choices about aspects of their lives, such as when they got up and went to bed; how and where they spent their day; and how often they chose to have a bath or a shower. One person had been offered a ground floor room where staff could better meet their needs, but they had chosen to remain in a top floor room as they enjoyed the company of other people who visited them to enjoy the far-reaching views from their window.
Another person told us, "I need help with baths, but can ask for one at any time, the choice is up to me." A further person said, "I like to have regular baths, and I get them in the morning which I like."
Records of daily care showed the choices people made were respected. For example, one person had declined to take their 'water tablet' as they were going out for the day. Staff understood the person's reasons and respected their decision.

The registered manager had recently introduced a key worker system. A key worker is a member of staff who is responsible for working with certain people, taking responsibility for monitoring that person's care and liaising with family members. Key workers were also responsible for reviewing the care plan for the person on a monthly basis and we saw these reviews had started to be completed. Records of discussions with people were recorded as part of the review, together with any changes they requested. One person said of their key worker, "They talk to me about my care and I can ask if I want something doing differently."

People had access to a range of activities to meet their individual interests. On the first day of the inspection, nine people went out for lunch to a local garden centre, which they clearly enjoyed. Through contacts with a local project, staff had arranged for a batch of eggs to be installed in a pen in one of the lounges, together with an incubator. The eggs had hatched and the chicks had been cared for by people. This had clearly been the highlight of the past two weeks for many people who spoke about it with enthusiasm. One person said, "We saw the chickens hatch; it was lovely." Another person told us, "I'll miss the chicks; I used to clean them out." Staff from the same project had also brought other animals to the home for people and their families to meet, including a llama and an alpaca. Another local group had brought in a bird of prey to demonstrate its skills. A picture board had been created to remember these days, to which three people drew our attention and told us they had enjoyed the events very much. People had also adopted a donkey from a nearby donkey sanctuary, which they and their families had met. A staff member told us, "The residents love interacting with the animals; it's lovely."

A singing group attended on some weekends, to which people and their families were invited. One person attended a day centre to socialise and engage in painting and craft work. Another person told us they enjoyed trying to do small jobs around the home, such as sorting out the cutlery and laying the tables. A further person told us, "I do knitting and have made 50 bonnets for [a hospital charity]." People's care plans contained information about their hobbies, backgrounds and interests. Plans were in place to convert one of the lounges into an activity room and people were being canvassed to identify future activities they wished to take part in. One person said of the staff, "They're going to have an activity room. I've told them I like the bingo and the board games, but I don't like ball games."

Staff sought and acted on feedback from people and their families. Talk time was used to seek people's views and questionnaire surveys had been conducted to seek the views of relatives. A response to the latest survey identified a conflict between family members wishing to be informed about changes to their relative's health and people not wishing to share the information with their family members. The registered manager had responded by introducing a procedure to clarify with each person the information they wished to share with their relatives. Feedback also showed people had not been satisfied with the level of activities; this had been addressed by arranging for the animals to visit and developing an activities room for people.

There was an appropriate complaints policy in place, which was advertised in information given to people when they moved to the home. Records showed no formal complaints had been received in the past year; the registered manager told us they resolved all minor concerns as and when they arose. All but one person said they knew how to make a complaint and said they would talk to staff. One person said, "I've got no complaints at all, but if I did have a complaint, I'd talk to [the registered manager]; she's very nice."

Requires Improvement

Our findings

Providers are required by law to notify CQC of significant events that occur in care homes. This allows CQC to monitor occurrences and prioritise our regulatory work. Whilst most significant events had been notified to CQC, we identified one incident which had not been notified as required. A person had had a fall at the home, broken their hip and been admitted to hospital. We raised this with the registered manager who told us they thought the hospital would have informed us of this; however, this is not the responsibility of the hospital.

Providers also have to follow a duty of candour, which requires them to be open and transparent when people in their care are harmed. The service had a duty of candour policy in place, which specified the need for certain information to be given to the person or their relatives in writing after an incident such as a serious fall. We found the registered manager had provided this information verbally to the person who had fallen, but had not followed it up in writing. We discussed this with the registered manager who prepared a template letter which could be used to provide this information in the future.

The systems designed to assess, monitor and improve the service were not always effective. For example, a spreadsheet was used to monitor staff training. Although this had identified that staff moving and handling training was out of date, effective action had not been taken to address it. Care plans were reviewed monthly by key workers, but the reviews had not identified the lack of appropriate equipment to move one person safely or the lack of information about how to prevent the person from developing pressure injuries.

An audit conducted by a community pharmacist confirmed that medicines were managed appropriately. Advice on further improvements that could be made had been accepted by the registered manager and were being implemented. However, we identified that the provider's medication policy was not up to date. It referred to previous regulations that were no longer in force. It did not refer to the latest guidance issued by the National Institute for Health and Care Excellence (NICE). It did not reflect current practices at the home in relation to where medicines were stored or how they were administered. We discussed this with the registered manager who told us all the provider's policies were due to be reviewed imminently.

An infection control audit had been completed in October 2015 which confirmed appropriate arrangements were in place to control the risk and spread of infection. The registered manager showed us a template they were planning to introduce to conduct spot checks of key aspects of the service at varying times of the day. These would be unannounced and would assess whether staff were caring for people safely and effectively.

People enjoyed living at Victoria House and told us it was well-led. One person said, "I like living here very much. It's well organised. I see the [registered manager] and could talk to her if I had a problem; she's very approachable." Another person told us, "[The registered manager] is quite good. Everything has been very different since she came. Things have improved."

Staff described the management as "supportive". One staff member said, "[The registered manager] is good; she is someone you can lean on." Another told us, "The regime is a lot better than it was. We used to have problems with staff leaving and paperwork getting behind, but we're now up to strength [with staff numbers]." The registered manager told us they received appropriate support from the provider through daily contact either on the phone or in person. In order to keep up to date with best practice, the registered manager attended events organised by the local care homes association and reviewed information circulated by trade associations.

Staff were motivated and were clear about their roles and responsibilities. A 'daily planner' was used to delegate tasks to staff and ensure they were available to people. People said they were supported by sufficient staff to meet their individual needs. A staff member told us, "I love working here. I like the residents, like the staff and get on well with the manager. I can go to her and she listens."

There were appropriate arrangements in place for staff to share important information about people. A 15 minute overlap period was provided when the oncoming shift could be briefed by the outgoing shift, to help ensure staff were kept up to date with the support people needed or had received.

Staff showed a strong desire to make improvements and develop the service for the benefit of people. They were receptive to our feedback and keen to explore ways of achieving positive outcomes for people. The provider had a set of values they expected staff to work to. These included promoting people's privacy, dignity, choice, and independence. Our observations and discussion with staff confirm that they understood and worked to these values in the way they cared for people on a day to day basis.

The registered manager, who had been in post for a year, told us they were "tightening up" the way the home was run. For example, they were introducing a more robust attendance management policy to address unacceptable levels of sickness with some staff. They had sent letters to staff who had not completed their online training advising them of the potential consequences. They had also taken over responsibility for ordering the food each week as they said the budget had become "out of control".

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 failed to ensure that care and support were only provided to service users with the consent of the relevant person. Regulation 11(1), (2) & (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that individual risks to service users were assessed and managed effectively. Regulation 12(1) and 12(2)(a)&(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure that persons employed at the home were of good character and that information specified in Schedule 3, relating to required checks, was available for each person employed. Regulation 19(1)(a), 19(2)(a) & 19(3)(a).

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider had failed to ensure that staff received appropriate training to enable them to carry out the duties they were employed to perform. Regulation 18(2)(a).