Care Quality Commission

Tamaris Healthcare (England) Limited

Victoria Lodge Care Home

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

Overall summary

Victoria Lodge Care Home is registered to provide accommodation and nursing or personal care for up to 46 people. It is a purpose-built care home with two units. The ground floor unit provides care for younger adults who are physically disabled and the first floor provides care for frail older people, some of whom may be living with dementia. At the time of this visit there were 14 people living on the ground floor unit and 23 people accommodated on the first floor, two of whom were staying for a short-break.

This inspection took place over two days. The first visit on 13 October 2015 was unannounced which meant the provider and staff did not know we were coming. Another visit was made on 14 October 2015.

There had been three changes of manager since the last inspection. The new post-holder had begun the process of applying for registration as a manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

At the last inspection of this care home, which was carried out on 11 and 12 February 2015, we found the provider had breached two regulations. These related to: care records which did not always reflect people's needs; and lack of staff supervision. After the inspection on 11 and 12 February 2015 the provider wrote to us to say what they would do to meet legal requirements.

During this inspection visit we found that new care records had been put into place, which were an improvement, and staff had received some supervision and this was on-going. This meant the provider was addressing these areas and was no longer in breach of those regulations.

However we found other breaches of regulations during this visit. These related to the safe induction of agency staff and to the records about medicines.

There were only four permanent nurses working at the home to cover day and night time, so there had been several shifts where agency nurses were in charge. People said they felt they were being looked after by "strangers". Agency staff received a handover about people's care needs. However the home had not made a record of whether agency staff had an induction of the home, including fire safety and contingency plans, before they started their shift. This meant when the agency nurses were in charge they may not know what to do in the event of an emergency, which presented a potential risk for people living there.

Medicines records were not always completed, so it was difficult to tell if someone had received their medicines or not. Some people needed 'as and when required' medicines but the guidelines about this for staff were not detailed enough to show when those medicines might be necessary. For example some 'as and when required' guidelines simply stated that the medicine was for 'pain', but some people were not able to express when they were in pain.

You can see what action we told the provider to take at the back of the full version of the report.

People and their relatives were positive about the service. People said they felt safe and comfortable with the permanent staff at the home. Staff were clear about how to recognise and report any suspicions of abuse. Staff told us they were confident that any concerns would be listened to and investigated to make sure people were protected.

Since the last inspection staff had had some opportunities for more training and supervision but this was still in progress and the new manager recognised that further improvements were needed to how this was recorded.

Staff understood the Mental Capacity Act 2005 for people who lacked capacity to make a decision and deprivation of liberty safeguards to make sure they were not restricted unnecessarily. People's safety was protected without compromising their rights to lead an independent lifestyle.

People who used the service and their relatives told us they felt well cared for in the home. People were supported to eat and drink enough to meet their nutrition and hydration needs. Any changes in people's health were referred to the relevant health care agencies.

People and visitors were positive about the care and kindness they received from staff. One person told us, "I am so very satisfied. This is better than being at home. The staff are very good to me." Another person commented, "The staff get me what I want. The place is clean and tidy. The staff are very good."

There was a good rapport between people and the staff on duty. Staff chatted to people as they passed and people were assisted in a cheerful way. A visitor told us, "This place is spot on. My [family member] is well cared for and we are happy. The staff even take him for a drink to the pub on Fridays."

People and relatives told us there was a good range of activities at the home. Staff made sure people had the chance to go out shopping or to local places of interest, including the church and pub. People had information about how to make a complaint or comment and these were acted upon.

Summary of findings

There had been three changes to the management of this home this year. People told us they felt sorry for the staff because of all the changes in management. Staff said that it had been a "struggle" with the changes in management to create stability.

The provider had a quality assurance programme to check the quality of the service. This included improvements to the way people's views were sought and acted on.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe. Medicines records were not always completed so it was not always possible to tell if someone had had their medicines.

The home had been using agency staff several times a week but there were no records about whether they had been shown what to do in an emergency.

Staff knew how to report any concerns about the safety and welfare of people who lived there.

Requires improvement

Is the service effective?

The service was not always effective. Staff supervision and training had improved since the last inspection, although this was still a work in progress.

Staff understood how to apply Deprivation of Liberty Safeguards (DoLS) to make sure people were not restricted unnecessarily, unless it was in their best interests.

People said they enjoyed their meals and had choices. People were helped to access other health care services whenever this was required, and the home staff worked well with those services.

Requires improvement

Is the service caring?

The service was caring. People and their relatives said that permanent staff members were caring and kind.

There was a friendly atmosphere in the home and people said they were treated well.

People made their own choices about how they spent their day, when and where they dined and whether to take part in events at the home.

Good

Is the service responsive?

The service was not always responsive. Care records had improved since the last inspection, although this was still a work in progress.

There were activities for people to participate in, either individually or in groups, to meet their social care needs. There were opportunities for people to go out in the local community.

People knew how to make a complaint or raise a concern. They were confident these would be listened to.

Requires improvement

Is the service well-led?

The service was not always well led. This was because there was not a registered manager at the home, and there had been three new managers since the last inspection.

Requires improvement

Summary of findings

People and relatives had the chance to give their comments and suggestions at meetings or individually via the new on-line surveys they could complete at any time.

People and staff felt the culture in this home was friendly and welcoming. The provider had systems for checking the quality and safety of the care service.

Victoria Lodge Care Home

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 started on 13 October 2015 and was unannounced. The inspection team consisted of an adult social care inspector, a specialist adviser 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. A second visit was carried out on 14 October 2015.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection, we reviewed the information included in the PIR along with other information about any incidents we held about the home. We contacted commissioners, dietitian and speech and language therapy services, and also the safeguarding team of the local authority before the inspection visit to gain their views of the service provided at this home. We contacted the local Healthwatch group to obtain their views. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with 14 people living at the home and four relatives and other visitors. We spoke with the manager, a regional manager, deputy manager, a nurse, four care workers, an activity staff member, and a catering staff member. We observed care and support in the communal areas and looked around the premises. We viewed a range of records about people's care and how the home was managed. These included the care records of eight people, the recruitment records of three staff members, training records and quality monitoring reports.

Requires improvement

Is the service safe?

Our findings

At the time of this inspection the home had vacancies for 55 nurse hours. As a result the provider had to use agency nurses to cover gaps in the staff rota. In the two weeks before and during this inspection, the home had used 10 different agency nurses on 15 shifts covering days and nights. The agency nurses were responsible for ensuring the safe care and welfare of the people who lived there. They were included in handovers about the care needs of people who lived there at the start of their shift. However of the 10 agency nurses who had worked there, only one had a written record of the required induction programme before they began working at the home. The induction programme included fire safety and emergency procedures. This meant people were being cared for by agency nurses who had no demonstrable knowledge of safe working practices within Victoria Lodge. In discussions the deputy manager stated that all agency staff were provided with an induction however this had not been recorded. This was contrary to the provider's own protocols for use of agency staff. This meant the provider could not be certain that the staff working at the home were suitable and experienced.

Nurses were responsible for administering medicines for people who needed support with this. The home's permanent nurses had been trained in this and had an annual competency check. However records about people's medicines were not always completed in a safe way. We looked at the medicines administration records (MARs) for people using the service. In most cases there were photographs attached to these records so staff could identify the person before they administered their medicines.

However some people's photographs were missing. This was important because the home was using several agency nurses who would not be familiar with people living at the home, so this increased the possibility of medicines being given to the wrong person. In a small number of cases, some key information was also missing from their medicines records such as room number, GP and any allergies.

There were several occasions were the medicines administration records (MARs) had not been completed. This meant it was not possible to know if those people had been given their medicines or not, so their health and well-being might have been affected. The home operated a daily stock count of medicines that were stored in boxes (rather than the blister packs that were usually used). There were several days where the daily stock count had not been completed so it was difficult to know how many tablets should be left. This record was not a legal requirement but was part of the provider's own procedures to monitor the safekeeping of medicines. The new manager felt that some of these gaps were because agency nurses would not be familiar with the procedures.

There was no clear guidance for supporting individual people with 'as and when required' (PRN) medicines. For example some people, who were unable to express pain due to their cognitive decline, were prescribed 'as and when required' paracetamol. The PRN forms stated the paracetamol should be given "for pain" but did not describe how each person might present if they were in pain. This meant people may be experiencing pain which would not be noticed by new or agency nurses, so people were at risk of not being offered their prescribed pain relief.

The security of medicines storage was appropriate. However records about checks of the ambient temperature of a medicines storage room had not been completed on several days, which was contrary to good practice and to the provider's own protocols.

These matters were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the people we spoke with assured us they felt safe at the home. One person told us, "I like it here." Another person said, "I am happy here." Relatives also felt the home provided a safe service for people who lived there. One relative told us, "I am very satisfied by the attention the staff give my [family member]."

All the permanent staff members we spoke with were knowledgeable about safeguarding and whistleblowing procedures and felt confident in raising any concerns should they need to. Staff told us, and records confirmed, they received training in safeguarding vulnerable adults. All staff, including housekeeping and catering staff, had access to on-line training in safeguarding adults which they were required to complete at least annually. There had been three safeguarding referrals since the last inspection. These had been appropriately reported and dealt with via the local authority safeguarding processes.

Requires improvement

Is the service safe?

In care records there were risk assessments relating to individual people's needs, for example a person with epilepsy who regularly had seizures had a well-constructed care plan which was reviewed regularly and had a seizure recording chart in their file. There were risk assessments about people's mobility, nutrition and pressure care. Falls risk assessments were not yet completed for a small number of people, but the care home did have a systematic approach to recording and dealing with any falls. Accidents, incidents and falls were logged on a database (called datix) which was analysed by the provider's health and safety manager for any trends.

The provider had a system to check that the premises and equipment were safe. A maintenance person was employed full time. We saw there were daily, weekly, and monthly lists of checks and these were recorded in the maintenance log book. These included checks on radiator surface temperatures, window restrictors, electrical safety and electrical appliances, emergency lighting, and call bell and alarms systems. There were no health and safety hazards in the home during this inspection. There was a 'grab file' for any staff member to use in the event of an emergency in the home. The grab file included details of what to do and who to contact in the event of a flood, fire or staff absence. It also included the personal evacuation plans for each person who lived there.

People felt there were enough staff to assist them with their daily needs. They told us that staff responded as quickly as possible when they requested assistance. One person told us, "I cannot fault them. They come as quickly as they can."

At the time of this inspection the staffing levels comprised of two nurses and seven care workers through the day, and one nurse and three care workers through the night. Staffing levels were determined by a staffing tool called CHESS. This used the dependency levels of people (for example, if they had mobility needs or were cared for in bed) to calculate the number of nurses, care staff and auxiliary staff that were needed through the day and the number of nurses and care staff through the night. On the day of this inspection there were also three housekeeping staff, three catering staff, an activities staff member, a maintenance staff member and an administrator.

Although there were vacancies for nurses, there was a stable care staff team. We looked at the recruitment records of three new staff members. We found that recruitment practices were satisfactory and included applications, interviews and references from previous employers. The provider also checked with the disclosure and barring service (DBS) whether applicants had a criminal record or were barred from working with vulnerable people. This meant the provider had checks in place to make sure that staff were suitable to work with vulnerable people.

Requires improvement

Is the service effective?

Our findings

At the last inspection of this home in February 2015 we found the provider had breached a regulation relating to the support and development of staff. This was because staff had not received supervision or appraisals, so they were not being offered support in their role. Also there were few records of the training of nurses in specific nursing tasks that people required support with.

During this inspection we found that all staff had been involved in a group supervision session and some staff had had individual supervision sessions with their line supervisor. There were records of the training staff had completed. However this information was held in several different records so it took some time to extract specific information for individual staff, particularly about nursing tasks. The new manager agreed that an up-to-date training matrix and a training needs analysis would help to identify all the training that staff had completed. This meant the service had improved supervision and training since the last inspection but this was still a work in progress.

The people and visitors we spoke with felt staff were competent to carry out their roles. One visitor commented, "The staff are very professional." All the staff we spoke with said they felt equipped to carry out their role and described the support and supervision they received as adequate and helpful. They stated they had plenty of opportunities for training. Most care staff had achieved a national care qualification (called NVQ level 2) in health and social care. Staff also had necessary training in health and safety matters, such as first aid, fire safety, food hygiene and infection control. The provider used a computer-based training system for each staff member to complete annual training courses, called e-learning.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS), and to report on what we find. Staff understood DoLS to make sure people were not restricted unnecessarily, unless it was in their best interests. Over the past year staff had made DoLS applications to the local authority in respect of a small number of people who needed supervision and support at all times, and further applications continued to be made where appropriate.

Most people who lived here were able to make their own choices and decisions. We heard staff asking people for permission before they supported them, for example with personal care, at mealtimes or with medicines. In a small number of care records we saw assessments of people's capacity before any major decisions were made on their behalf, for example about the use of bedrails for their safety. It was clear from care records that staff involved other care professionals, and relatives where appropriate, to ensure people's best interests were protected without compromising their rights.

The home was spacious with wide corridors and there were several small lounges and areas set aside for quiet reflection and relaxation. The ground floor unit was specifically designed for people with physical disabilities so all areas were large enough for people to manoeuvre wheelchairs. Bedrooms were large enough for people to be supported from both sides of their bed.

Staff had tried to make the environment as homely as possible with pictures and other cosmetic touches, however the overall decor and fabric of the building looked tired and worn, particularly in bathrooms and main corridors. Bathrooms were dimly lit, with scuffed walls and marked flooring. (The regional manager confirmed that a budgetary request for refurbishment of these areas had been agreed and it was anticipated that works would be carried out early in 2016.)

People and relatives felt the quality of the meals was "very good". One person commented, "The food is lovely." Another person told us, "It is a good menu. There is always a choice." A relative said, "Just look at my family member. He has put on weight since he came in here. The food must be good". One person who was staying for a short break suggested that there should be fresh vegetables and fruit available and commented, "I would like a banana now and again" and, "We only get tinned fruit."

Some staff had attended training in dysphagia (swallowing difficulties) and felt confident about supporting people in the right way with drinks and foods. The catering staff had a list of people's dietary needs, and they were knowledgeable about how to prepare soft or pureed foods if people required this. The care staff kept a record of people's weight and monitored people's food and fluid intake if they were at risk of losing weight. There were nutritional care plans for most people to guide staff in providing the right dietary support for people.

Requires improvement

Is the service effective?

We joined people for a lunchtime meal in one of dining rooms. The food was of good quality. There were pureed foods for people who needed their meals prepared in this way. The cook and staff were familiar with people's special dietary needs, for example if they required a 'soft' diet or were diabetic. People who needed physical assistance to eat their meal were assisted with this at their own pace and in an unhurried way.

Community dietetic services told us that the home was the first choice preference for when patients were discharged from hospital to a care home with a nasogastric tube in situ. (This is a way of feeding through a tube from the nose to the stomach.) The home also supported people who required PEG feeding (this is a way of providing liquid food directly into the stomach via a tube). Staff who provided this support had had training in this.

People were provided with hot drinks at regular intervals during the day. There were also juice dispensers and water machines in some lounges and dining areas. However there were no cups or beakers available for people to help themselves to those drinks.

People felt the staff supported them to access other health care agencies when needed. It was evident from care records that people were supported to maintain good health, with regular eye and dental check-ups. People were supported to access their own GP and other primary care services such as dietitians and occupational therapists along with specialist care services such as consultant neurologists and community psychiatric teams.

Good

Is the service caring?

Our findings

People and visitors were positive about the care and kindness they received from staff. One person told us, "I am so very satisfied. This is better than being at home. The staff are very good to me." Another person commented, "The staff get me what I want. The place is clean and tidy. The staff are very good."

A visiting relative told us that their family member had previously lived in another care home but that it was not as good as this one. They said, "This place is spot on. My [family member] is well cared for and we are happy. The staff even take him for a drink to the pub on Fridays."

Another visitor told us, "My [family member] gets excellent attention here. They attend to [their] needs in an excellent way."

There was a good rapport between people and the staff on duty. Staff chatted to people as they passed. We overheard one staff member going in and out of people bedrooms to ask if they would like a variety of drinks. The staff member also asked people if they would like their bedroom door shut and if she could get them anything else. This was carried out in a respectful and cheerful way.

We saw staff adapted their approach depending on who they were talking with, for example speaking clearly and slowly for people who needed more time to make a choice. For another person with a visual impairment staff described where their food was on their plate so they could be as independent as possible.

People said they had a good relationship with permanent members of staff. One person told us, "The staff have a good sense of humour. They answer the bell quick. They give me my medicine when I need it."

During a lunchtime meal we saw people who needed some support were assisted in a sensitive, engaging way. For instance one person needed full assistance to be fed and this was carried out at the person's own pace. The care worker sat with the person all the way through the meal, only leaving them briefly to get their dessert. The staff member and person chatted throughout the meal in a friendly way. This made it a pleasant dining experience for that person.

It was good to see that the menu had been developed since the last inspection to include more meals that would suit younger people, such as curries and pasta dishes. This meant people now had a choice of traditional or modern dishes. People told us they had good choices about when and where to dine. For example, several people enjoyed a late breakfast and one person told us they could have a cooked breakfast every day if they wanted. People also preferred to have a lighter lunch and a main evening meal so this was the dining arrangement.

People's care records identified whether they could make complex decisions, or where they needed support from other people, including advocates. People's records also showed that they made their own daily choices and decisions.

The care records we looked at were written in a valuing way that aimed to promote the self-esteem of people. For example, one person's care plan about personal appearance stated, "[Name] requests her hair to be cut short which she really suits."

There were many examples during this visit of the respect shown by staff towards the people who lived there, so it was disappointing to observe one person being wheeled through a main corridor back to their room after a shower with only a towel across them. This practice did not preserve the person's dignity. We told the new manager about this and accepted that it was an isolated incident. She agreed that senior and nursing staff should be observing and correcting staff practice to make sure that the culture in the home remained a friendly but appropriate one where people were always supported in a dignified way.

Requires improvement

Is the service responsive?

Our findings

At the last inspection of Victoria Lodge in February 2015 we found the provider had breached a regulation relating to care planning records because people's significant needs were not always set out in a plan of care.

Since then the provider had redesigned the care planning documentation which included a comprehensive set of core and optional care plans. In addition there was another folder specific to each person and kept in their room which contained care charts such as positional change charts and moving and assisting assessments. The new system also included hazard warning stickers that could be placed in the person's room folder which brought staffs' attention to key areas of risk such as moving and assisting and choking risks, but these had not been put into use yet. Staff told us the new care plan records were an improvement. The staff reviewed individual care plans on a monthly basis but it might be helpful also to have a structured annual review of each person.

We looked at the care records for eight people. Where the new care plans existed it meant those people's needs had been reviewed and their care plans were up to date. The new care plans were personalised and reflected people's individual needs. For example, one person's care plan about medication stated the person "likes you to explain what tablets you are administering due to her poor vision".

A small number of old care plans still existed and these were yet to be reviewed. We saw that one person's care file included a risk management plan about a person's individual behaviour but this was not yet set out in a care plan. However the staff were still reviewing this person's file and the care plan was being developed during this visit. This meant care plans had improved since the last inspection, but because some people's care files had not yet been changed to the new system, this improvement was still a work in progress.

The home employed a full-time activities co-ordinator. On one day of the inspection we did note there were some people on the first floor who spent much of the time in their own rooms alone without much to stimulate them. However on the second day several people were taking part in games of dominoes and 'knit and knatter' groups. People from the first floor enjoyed spending some time in the ground floor dining room where they could socialise with people from the ground floor unit. One staff member felt there should be more activities for people on the first floor.

One relative commented, "My [family member] loves to come down every morning for the activities." There was a weekly programme of group and individual events. Some people enjoyed going out with staff to the local shops and supermarket. There were occasional trips out in the minibus, and a regular weekly lunch outing to a nearby pub. One person described how they went to a local church every Sunday.

One visiting relative told us, "The activities in here are great. [The activities co-ordinator] is super at her job. She does manicures and so on. Nothing is a bother for her." People told us entertainers were hired on a regular basis and sing-alongs were held regularly with a karaoke machine. Local community groups were encouraged to come in to the home to entertain and church members came in to administer Communion. The home had a garden area with seating and several people told us they enjoyed sitting out there on good weather days.

People and their relatives said they would feel able to raise any concerns if necessary. There were posters in the reception area about how to make comments, complaints or compliments.

There had been one complaint recorded since the last inspection. This related to an item of clothing that had been damaged by the laundry. The complaints record showed the details of the complaint, the investigation and outcome, and the satisfactory resolution.

Complaints were now recorded on the provider's datix (management reporting tool) so the provider could analyse complaints for any trends and make sure that outcomes or actions were completed.

Requires improvement

Is the service well-led?

Our findings

There had been three changes to the management of this home over the past year. This meant there had not been a registered manager in post during 2015. The new manager stated they had started the process of applying for registration with the Commission.

People told us that the changes in management must impact on the staff. One person told us, "I feel sorry for the staff. There have been so many managers. I believe the managers need more support from the owners." Another person said, "The care here is ok, but there have been too many changes [to management]." Two relatives also commented on the number of management changes. One said, "They have had good managers here but there is too much pressure in the job so they leave."

People had various opportunities to give their views and suggestions about the service. The provider had introduced a new 'quality of life' feedback system in its services. This meant people, relatives and other visitors could leave their comments about the home at any time on an easy- to –use iPad computer that was sited in the entrance hallway. People could also request the iPad to be brought to them so they could input their comments at any time. The comments would be 'live' and any significant comments would be emailed immediately to the manager for action and this would be recorded on the system.

We saw that the most recent analysis of people's views had been very favourable. At the time of this inspection 13 people had completed the on-line questionnaire since the new 'quality of life' system was introduced in July 2015. All of those people had stated they felt safe, they felt they were treated as an individual and all felt they were treated with respect by the staff. A small number of relatives had also completed the questionnaire on the computer. All their responses were also favourable and all felt their family members were safe, respected and there were sufficient activities.

Resident/relatives' meetings were also occasionally held which gave people a chance to give suggestions as a group. At the last meeting in August 2015 people, relatives and staff had discussed activities, menu suggestions and staff cover arrangements.

People, relatives and other visitors told us the atmosphere in the home was "friendly and welcoming" and the ethos amongst staff was good. The staff we spoke with felt supported within the home and commented that the deputy manager was always happy to be approached for advice.

Some staff had worked at the home for several years and most felt there was usually good team work. Staff said they enjoyed their jobs. However staff also commented that it had been a "struggle" with the changes in management to create stability and improve the overall caring culture of the service. Some staff also felt unappreciated by the organisation and one said, "It would be nice to get the occasional thank-you."

There were opportunities for staff to discuss the running of the home at staff meetings. The manager and senior staff, including nurses, held meetings every two months to discuss supervisory areas such as care plans, supervisions and training targets. The remaining care staff had attended a meeting in March 2015 and another in September 2015. The discussions included: expected practices and conduct; more timely response to people's support at breakfast-time; training; and staff were thanked for their help with a recent funeral that was held at the home. Night staff had also held meetings to discuss access to people's continence equipment, care records and cleaning duties. This meant staff had the chance to contribute to the running of the home, together with communicating key information to staff to ensure standards of care were maintained or improved.

The provider had a quality assurance programme which included monthly visits by a regional manager to check the quality of the service. We saw the reports of these visits included action plans and timescales for any areas for improvements. The manager also kept a weekly report of any issues about the health and well-being of people that needed to be monitored, for example weight, pressure care and infections.

Staff at the home carried out a number of regular audits of the service, including care records, premises and infection control checks. Many of the checks were now recorded on a new quality tool that involved inputting the information onto an iPad. This computer-based system then analysed the results and identified any actions for improvement.

The service was also audited by external professionals such as commissioners. In January 2015 the home had scored 44% on a joint audit carried out by commissioners of the

Requires improvement

Is the service well-led?

local authority and clinical commissioning group (CCG). This had improved to 58% at the last audit in May 2015 and the staff were working to an action plan to improve this further.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were being cared for by agency nurses who had no demonstrable knowledge of safe working practices within Victoria Lodge. Regulation 12 (2)(c) People were not protected against the risks associated with unsafe management of medicines. Regulation 12(2)(g)