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

Summary of findings

Overall summary

Victoria House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home accommodates up to 22 people. At the time of our inspection 16 people were living at Victoria House. 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 and most bedrooms had en-suite facilities.

There was a registered manager in post at the service. 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 and associated Regulations about how the service is run.

This inspection took place on 5 and 8 February 2018 and was unannounced. At our last comprehensive inspection, in August 2017, we identified breaches of Regulations 12, 17, 19 and 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure: that medicines were managed safely; that accurate and complete records or people's care were maintained; that effective quality assurance systems were operated; that safe recruitment practices were followed; and that the previous performance rating was displayed on the premises or on their website. Following the inspection, we issued warning notices for the breaches of Regulations 17 and 19 and requirement notices for breaches of Regulations 12 and 20A. The provider sent us an action plan detailing how they would become compliant with the Regulations.

At this inspection, we found although significant improvements had been made, further improvement was still required. The registered manager took prompt action to address all the concerns raised during this inspection. However, a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was identified. You can see what action we have taken at the back of the full version of the report.

The provider had significantly enhanced their oversight of the service since the last inspection. However, we found their quality assurance systems were still not operating effectively as there was no system in place to audit people's care plans to ensure they were up to date and reflected people's current needs.

Most medicines were managed safely, although no action had been taken when the temperature of the medicines fridge had been too low and risk assessments had not been completed for people prescribed blood thinning medicines.

Action was taken to protect people from the risk of falling. However, people's risk assessments were not updated after they had experienced falls to ensure staff were aware of additional measures that were

needed to prevent further falls.

A recruitment procedure was in place, although the provider did not have a process in place to assess any health issues that might affect their work.

Care plans included information about people's routines and staff demonstrated an extensive knowledge of people's current needs. However, some care plans lacked key information about people's individual needs, including their end of life wishes. This posed a risk that people's needs and preferences might not be met consistently.

There were enough staff deployed to meet people's needs. People told us they felt safe at Victoria House and staff understood their responsibilities to safeguard adults at risk of abuse.

Procedures were in place to learn from adverse incidents and there were appropriate systems to protect people from the risk of infection.

People's needs were met by staff who were skilled and suitably supported by managers. Staff followed legislation to protect people's rights, promoted choice and empowered them to make as many of their own decisions as possible.

People praised the quality and variety of meals and were supported appropriately to eat and drink enough. They had access to a range of social activities.

People were supported to access healthcare services and there were arrangements in place to help ensure that people received consistent support when they moved to or from Victoria House.

The environment was supportive of the people who lived there and met their needs. People were supported by caring staff who knew them well. Staff encouraged people to remain as independent as possible and involved them in decisions about their care. They protected people's privacy and dignity at all times.

People told us they enjoyed living at Victoria House and felt it was run well. The provider sought feedback from people. People described an open and transparent culture where they were able to raise concerns or complaints.

Staff spoke enthusiastically about their work and said morale had improved significantly since the last inspection. They expressed a shared commitment to supporting people to the best of their ability.

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.

Medicines were managed safely and people were supported to take the medicines as prescribed. However, action was not taken when the temperature of the medicines fridge was too low and risks assessments for people using blood thinning medicines were not completed until we identified these issues during the inspection.

Individual risks to people were managed effectively, although people's risk assessments were not always up to date to help ensure staff supported people consistently.

Appropriate recruitment procedures were in place and followed. However, the provider did not have a process to check the health status of applicants until we identified the issue during the inspection.

There were enough staff deployed to meet people's needs. People said they felt safe and staff understood their safeguarding responsibilities.

Procedures were in place to learn from adverse incidents. There were systems in place to protect people from the risk of infection.

Is the service effective?

Good

The service was effective.

People's needs were assessed before they moved to Victoria House. People's nutritional needs were met and they had access to a wide choice of meals and drinks.

People's needs were met by skilled staff who were supported appropriately in their role by managers. Staff only provided care and support with people's consent.

People were supported to access healthcare services. There were clear procedures to help ensure people received consistent support when they moved between services.

The environment was supportive of the people who lived at Victoria House.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and compassion. They knew people well and interacted positively with them at all times.

Staff respected and promoted people's independence. They protected people's privacy and respected their dignity.

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

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans did not always contain sufficient information to support the delivery of personalised care and ensure people's end of life wishes were met. However, staff knew people well and demonstrated an in-depth knowledge of their individual needs.

Staff responded promptly when people's needs changed. They promoted choice and empowered people to make decisions.

People were supported to access a range of activities. There was a complaints procedure in place and people felt able to raise concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Although the provider had taken action to significantly enhance their oversight of the service, further improvements were required. Quality assurance systems had not ensured that accurate information about people's needs was recorded consistently.

People told us they enjoyed living at Victoria House and felt it was run well. Staff spoke enthusiastically about their work and expressed a shared commitment to supporting people to the best of their ability.

There was an open and transparent culture and the provider actively sought feedback from people, visitors and staff.

Victoria House

Detailed findings

Background to this inspection

We carried out this comprehensive 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.

The inspection was also planned to follow up on the warning notices we had issued following our last comprehensive inspection, in August 2017, for breaches of Regulations 17 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This inspection took place on 5 and 8 February 2018 and was unannounced. It was completed by one inspector.

Before the inspection we reviewed all information we had received about the service, including the provider's action plan for improvement and notifications. Notifications are information about specific important events the service is legally required to send to us.

We spoke with nine people who use the service and two family members. We spent time observing the way staff interacted with people who use the service. We also spoke with the registered manager, the deputy manager, six care staff, a maintenance worker, two cooks and a housekeeper. Following the inspection, we received feedback from three health or social care professionals who had contact with the service.

We looked at care plans and associated records for seven people and records relating to the management of the service, including: duty rosters, staff recruitment files, accident and incident records, maintenance records and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

At our last comprehensive inspection, in August 2017, we identified breaches of Regulations 12, 17 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure that medicines were managed safely; had failed to maintain accurate records of the care needed to keep one person safe; and had failed to follow safe recruitment procedures. At this inspection, we found action had been taken and there were no longer breaches of these regulations. However, some further improvement was still required.

Most medicines were managed safely. There were clear processes in place and followed to obtain, administer, record and dispose of medicines. Medicines that needed to be stored at cool temperatures were kept in a secure medicines fridge. Although staff monitored the temperature of the fridge, to check it remained within a safe range, we found they had not taken action when the temperature had repeatedly been too low and was outside of this range. This meant medicines may no longer be safe for use. We discussed this with the deputy manager who adjusted the fridge and put measures in place to help ensure staff would take action in the future. They also contacted the pharmacy to check whether the medicines would be safe to use.

We found risk assessments had been completed for people who self-administered some of their medicines. However, risk assessments had not been completed for two people who were prescribed blood thinning medicines that could compromise their safety if they sustained an injury. We discussed this with the registered manager and by the end of the inspection appropriate risk assessments had been completed.

Medicines were only administered by senior staff who were suitably trained and had been assessed as competent. Records showed people had received their medicines consistently and as prescribed. The deputy manager checked people's medicines every week and took prompt action if they identified any issues, including if people ran short of medicines, had adverse reactions or needed 'as required' medicines more frequently than usual. They also monitored the quantity of medicines in stock to avoid unnecessary wastage.

People were protected from the risk of falling and action was taken when people fell. For example, their level of risk was reviewed; pressure-activated mats were installed to alert staff if people moved to an unsafe position and GPs were contacted to review the person's medicines. One person showed us a rail that had been installed to prevent them falling out of bed which they said made them "feel more secure". However, we found the updated assessments of people's risks and the additional measures taken were not always recorded. We discussed this with the registered manager and by the end of the inspection they had implemented a new system of 'multi-factorial risk assessments'. These would enable them to take a structured approach to assessing risk and help ensure that all relevant factors were considered.

Other risks to people were managed effectively. For example, some people were at risk of developing pressure injuries and we saw special pressure-relieving mattresses and cushions had been provided. We saw these were set correctly according to the person's weight. The condition of people's skin was closely

monitored and one person, who was being cared for in bed was also supported to reposition every two hours. This had been successful, over an extended period, in preventing the person from developing any pressure injuries and had drawn praise from healthcare professionals because the person was very frail and at high risk.

Environmental risks were also managed effectively. Gas and electrical appliances were serviced routinely. Fire safety systems were checked regularly and work was taking place to improve the fire alarm. Staff were clear about what to do in the event of a fire. They had taken part in recent fire drills and been trained to administer first aid. In addition, each person had a personal emergency evacuation plan detailing the support they would need if the building had to be evacuated. Records showed evacuation procedures had been discussed with people and most people had also taken part in a fire drill to check they understood the procedures.

Clear recruitment procedures were in place. These included pre-employment reference checks and checks with the disclosure and barring service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. However, we found the provider did not have a process in place to check the health status of applicants, to assess any health issues that might affect their work. We discussed this with the registered manager and by the end of the inspection they had amended the recruitment procedures to include a health declaration by applicants.

There were enough staff deployed to meet people's needs. One person told us, "I'm loath to call [staff], but they come quickly when I do." A family member told us, "There seem to be enough staff whenever I visit." The registered manager took a structured approach to setting staffing levels based on people's needs and reviewed them on a monthly basis or if people's needs changed. We observed that staff responded promptly to people's call bells during the inspection, including when a person activated their alert mat.

People told us they felt safe at Victoria House. One person said, "I've got nothing to trouble me here, everything is very good." Another person told us they felt "very secure". Staff understood their safeguarding responsibilities. They had received safeguarding training and knew how to identify, prevent and report abuse. They were confident that managers would respond to any concerns they raised and knew how to contact external agencies for support if needed.

Procedures were in place to learn from adverse incidents. The registered manager investigated any injuries, including unexplained bruising, that people sustained. Records confirmed that the circumstances of each incident were explored thoroughly to help prevent any recurrence. In addition, on a monthly basis, the registered manager reviewed all falls that occurred in the home to identify any patterns or trends.

There were appropriate systems in place to protect people by the prevention and control of infection. All areas of the home were clean and systems were in place to check that all cleaning had been completed to a satisfactory standard. One person said of the cleaners, "They keep my room nice and clean and do all my laundry." Another person said, "[The cleaner] cleans my room from top to bottom twice a week, she's ever so good."

Staff had attended infection control training. They had access to personal protective equipment (PPE) throughout the home and wore this whenever appropriate. They described how they processed soiled linen, using special bags that could be put straight into the washing machine. Since the last inspection, new washing and drying machines had been installed and secure facilities had been built to store clinical waste safely.

Good

Is the service effective?

Our findings

At our last comprehensive inspection, in August 2017, we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to maintain accurate records of the people's needs. At this inspection, we found action had been taken and there were no longer breaches of these regulations. However, some further improvement was still required.

The registered manager conducted written assessments of people's needs before they moved to Victoria House. We saw a nutritional risk assessment had been put in place for the person identified at our last inspection who was at risk of malnutrition. However, we found that a nutritional risk assessment for a second person, who had lost three kilograms in weight over the previous month, had not been completed. Staff knew the person had lost weight, were using food charts to monitor how much they ate and had contacted the GP for advice. However, the absence of a clear plan meant the person's nutritional needs may not have been met in an effective and consistent way. We raised this with the registered manager who agreed to develop a nutritional care plan for this person.

People praised the quality and variety of meals. Comments from people included: "The chefs are really good. We have a wide choice [of meals]; there's something to suit everyone"; "The food is very good. There are main meals and more snacky meals if you prefer" and "The meals are very good and there's always a good choice."

People received appropriate support to eat and drink. Most people ate independently, but one person needed occasional support with soft foods, another needed prompting to remind them to eat and a third person was provided with suitable aids to make it easier for them to eat independently. At lunchtime, people were offered a choice of four main meals and four desserts. The desserts were served from a trolley, so people could see the options clearly and choose how much they had of each.

A choice of drinks was also available to people at all times, including water, lemonade and fruit squashes. When people were identified as being at risk of not drinking enough, staff used monitoring charts to record their intake. A staff member told us, "We measure the drinks now, so we know [the records] are accurate. We confirmed this when we observed staff supporting people to drink and then recording their intake.

People's needs were met by staff who were suitably trained, skilled and competent. One person said of the staff, "They do a good job. They certainly know what they are doing" and a family member described staff as "very competent". A healthcare professional who had regular contact with the home told us, "I have only ever seen the highest quality of care offered [to people]. It is a pleasant place to work and I have never had any problems in the years I have been visiting."

New staff completed an effective induction into their role. This included time spent shadowing, (working alongside experienced staff) until they felt confident they could meet people's needs. Staff who did not have a vocational qualification were required to complete training that followed the standards of the Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in

their daily working life. Experienced staff received regular training in all key subjects and were supported to gain additional vocational qualifications relevant to their role. For example, two staff members told us they were being supported to gain a level three qualification in health and social care.

Staff told us they felt supported in their roles. One staff member told us, "The [registered] manager is good. She shows you how to do things and makes you feel supported." An employee of the month scheme had recently been introduced and two staff who had won the award told us it had made them feel "valued" and "appreciated".

Staff had annual appraisals where they discussed their performance and development needs, together with group or one-to-one sessions of supervision with a manager to discuss any concerns they had. In addition, managers observed staff delivering care and support to check their practice was up to standard. Staff spoke positively about the support they received from management on a day to day basis. One told us, "We discuss how things are running, any changes that would help people or extra training. It's to try and make sure everything is up to standard." Managers also operated an 'on call' rota to provide advice and support to staff out of hours.

Staff only provided care and support with people's consent and followed the principles of the Mental Capacity Act 2005 (MCA). 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 Victoria House had full capacity to make decisions about their care. One person was living with dementia and we were told their cognitive ability was declining. With patient support from staff, the registered manager felt the person was still able to make decisions. However, the registered manager was seeking support from a representative of the provider to help them assess people's capacity more accurately, using appropriate tools.

Some people had signed their care plans, to confirm their agreement with aspects of their care, for example to use of bed rails to keep them safe. Others had given their verbal agreement for the use of an alert mat and this was documented in people's 'talk time' notes. Talk time notes were records of key conversations that nominated staff had with people. Staff described how they sought verbal consent from people before providing care or support and information in the front of people's care plans emphasised the need for staff to do this at all times. One staff member said, "You can't force someone to do something they don't want to do. It's their choice."

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. No DoLS applications had been needed for people living at the home, but the registered manager knew how to make applications when these became necessary.

People were supported to access healthcare services when needed. For example, one person had seen a specialist respiratory nurse and been given oxygen to help prevent them being readmitted to hospital. Another person told us, "[Staff] are very good at getting the [community nurses] to come and see me when I need them." A family member told us, "They [staff] called the doctor last week as [my relative's] legs started

to swell. They prescribed a water pill and they have their legs raised now." When we saw the person, we confirmed that staff had supported them to elevate their legs on a stool, in accordance with the doctor's advice.

There were clear procedures in place to help ensure that people received consistent support when they moved to or from Victoria House. A social worker who had contact with the home told us, "The [registered] manager was very supportive of [a person's] desire to return home [after a period of recuperation at Victoria House] and gave me the relevant information I needed to guide my assessment to support the [person] to return home." When people transferred to hospital or to another care setting, staff used prepared 'A&E grab sheets' to document people's care and support needs. This helped ensure continuity of care if the person moved to another care setting.

The environment was supportive of the people who lived there. People described Victoria House as "homely" and we saw they had furnished their rooms with furniture and personal possessions that were important to them. The registered manager described how they had equipped people's bathrooms with liquid soap and disposable towels to promote good hand hygiene for staff when supporting people. This had been done in a discreet way that did not appear "clinical" and helped retain the homely atmosphere.

People frequently commented on the sea views they enjoyed from their rooms and we saw rooms had been laid out to maximise these, for example by placing outward facing chairs by windows. People had also chosen individual pictures that were relevant to them for the outside of their doors to help them recognise which room was theirs.

Good

Is the service caring?

Our findings

People were supported by kind, caring and compassionate staff. Everyone we met spoke positively and fondly about the staff. They all described staff as "lovely" and said they were happy living at Victoria House. Comments from people about the staff included: "They're wonderful people; they've always got time for you"; "They're all very kind and very helpful and very patient"; and "I've got a good rapport [with staff], they treat me well". A healthcare professional who had regular contact with the home told us, "The staff are kind and caring towards the residents and that seems to reflect on the mood in the home."

Without exception, all interactions we observed between people and staff were positive and supportive, regardless of the staff member's role. For example, when a person mentioned to a cleaner that they felt cold, the cleaner supported the person to their room to get a cardigan and said, "Let's go and have a look and then you can choose which colour [cardigan] you want." The cleaner later came to tell the person they had finished cleaning their room and asked if they wanted to "go back to your nice clean room". They checked whether they could dispose of some packaging they had found in the person's room or whether the person wanted to keep it. This showed consideration for the person and their possessions. When another person became tired, while walking along a corridor, a care staff member fetched a chair so the person could take a rest. They stayed with the person until they had recovered and could complete their journey.

Staff clearly knew people well. For example, they understood how people liked to take their medicines, knew which chairs people like to use and knew how much sugar people liked in their drinks. When offering one person a choice of biscuits, a staff member said, "You like the plain ones don't you?" They then took time to find some of these for the person. Another person told us a staff member had brought them a china cat as they knew they liked cats. They said, "[The staff member] also brought me a cat calendar. She is lovely. They are all good."

Staff respected and promoted independence by encouraging people to do as much as possible for themselves. One person told us, "I like to do a bit [of my personal care] for myself, but when I can't they [staff] help me." Another person said, "I can wash my top half but I need help with the bottom half and they [staff] are fine with that." A staff member told us, "Most people can walk on their own, so we just stay behind them for support and may put a hand on their back if they [become unsteady] so they know we are there." We observed staff doing this and saw that it gave people confidence to continue to mobilise independently, but with the reassurance of a supportive presence.

Staff protected people's privacy and dignity at all times. We saw they knocked on doors before entering people's rooms and used 'Do not disturb' signs when supporting people with personal care. One person told us, "I prefer my door closed and they [staff] keep it closed when they're helping me." Staff described practical steps they took to protect people's modesty. For example, one staff member told us, "Being bathed makes some people feel exposed, so I try and keep them covered as much as possible with towels. You have to respect their privacy."

Staff used appropriate techniques to communicate effectively with people according to their individual

needs. For example, one person had hearing loss and staff made sure they faced the person, bent down to their level and spoke clearly. Other examples of supportive communication included the home's 'service user guide' that had been prepared in large print and photos of menus to help people choose their meals.

When people moved to the home, they were involved in discussing and planning the care and support they received. In addition, key workers were allocated 'talk time' to spend with people each month. A key worker is a staff member who takes a particular interest in a named person to help ensure their needs were met and to act as a point of contact with family members. The 'talk time' sessions gave people an opportunity to discuss their care and support needs and any changes they wished to make. A family member told us they were closely involved in their relative's care, with their permission. They said, "They [staff] discuss my [relative's] care with me all the time. I can read their notes and they call me if there are any problems."

During pre-admission assessments, the registered manager explored people's faith needs and whether they had a preference for male or female care staff to support them with personal care. They told us that other information about people's cultural and diversity needs would come out during 'talk time' sessions and the 'life history' work they had started doing with people to help understand their backgrounds. Records showed that one person had discussed their faith during a 'talk time' session and confirmed that it continued to be an important part of their life. Staff supported this by facilitating visits by ministers from a local church.

Requires Improvement

Is the service responsive?

Our findings

People told us they received personalised care and support that met their needs. One person said, "If I need anything, I just ask. They [staff] will do anything for you." Another person told us, "I get all the help I need. I even get my feet washed every night; it's lovely." A further person said, "We are all different and they [staff] treat us as individuals."

Each person had a care plan which contained individual information about their specific needs and how they wished them to be met. This included key information about people's preferred daily routines, such as when they liked to get up and go to bed and how many pillows thy preferred. However, the information in some care plans lacked information and did not always support staff to deliver personalised care to people in a consistent way. For example, one person had a urinary catheter. This is a tube inserted into a person's bladder to drain urine into an external bag. The person's care plan stated that the person needed support to empty and change the bag, but did not specify what support was needed or what signs staff should be alert to that might indicate the tube was blocked or an infection was present. We raised this with the registered manager and by the end of the inspection a catheter care plan had been developed to help ensure the person was supported in a consistent way.

Staff told us they supported people at the end of their lives to have a comfortable, dignified and pain-free death. This was confirmed by written feedback to the registered manager from a family member which stated, "Thank you for all you did for [my relative]. Your kindness, warmth and loving care really shone through." Staff had completed basic training in end of life care and described particular aspects of end of life care they felt were important; these included maintaining the person's dignity, managing any pain and ensuring their comfort.

However, staff had not explored people's end of life wishes and preferences with them and there was insufficient information about this in people's care plans. This posed a risk that people's preferences might not be known or respected, particularly if they had to be transferred to hospital or other care setting in their final days. The registered manager acknowledged this was an area for improvement and said they were intending to start discussions with people and their families at a forthcoming meeting. In addition, the registered manager and two senior staff had enrolled on an extended end of life training course with a local hospice to support them with this work.

The risks posed by a lack of information in the care plans were mitigated by a relatively low turnover of staff and the fact that staff knew people well. When we spoke with staff they all demonstrated an extensive knowledge of people, including their current needs and how they should be met. Staff kept records of the care and support they provided for people. These confirmed that people's needs had been met consistently. For example, they included 'turn charts' for people who needed support to reposition regularly and 'food and fluid charts' for people at risk of malnutrition or dehydration.

Staff responded promptly when people's needs changed. Feedback from a healthcare professional included: "Clients' continence needs and any changes to their needs are always dealt with swiftly." Staff

recognised that some people's needs varied from day to day and were able to accommodate this by providing as much or as little support as the person needed at any particular time. Because staff knew people well, they were able to recognise when people showed signs of becoming unwell or presented differently from usual. For example, paramedics were called when a person appeared 'dazed' and was not responding in their usual way; and a GP was contacted when staff recognised that a person was reacting adversely to a new medicine they had been prescribed.

Staff promoted choice and respected people's autonomy by empowering them to make as many of their own decisions as possible. A note in the front of everyone's care plan reminded staff to do this at all times. One person told us, "I can do as I please. I can stay here [in my room] or I can go and sit in the lounge. I am not restricted in any way." Another person, who was wearing a dressing gown, said, "Look at me, I'm not even dressed today. It's my choice. You can do what you like." A staff member told us, "[One person] didn't want to wash today, which was okay. You have to respect their wishes. They are at home and should be able to do what they want. [Another person] was sleepy yesterday, so we let her sleep. Today she feels better and is brighter." We saw people chose where to take their meals. Most people preferred to have breakfast in their rooms and lunch in the dining room, but this varied from day to day. One person told us, "I go down [to the dining room] for most meals, but when my legs are playing up I have them [in my room]."

People had access to a range of activities. Most people were able to initiate their own activities and entertainment. For example, one person liked to go dancing and other people liked to watch television or read. One person told us, "I can amuse myself alright. There's lots I could do, but I am addicted to the television." Staff organised some additional activities, including cake making, bingo and darts. These were advertised on the home's notice board and people were encouraged to take part. Staff told us they had started exploring people's backgrounds, interests and hobbies and said they would use this information to develop more meaningful activities for people.

People told us they felt able to raise concerns or complaints with the management, although all said they had not had cause to complain. One person said, "If I needed to make a complaint, I'd see [the registered manager] as she's the boss, but I've not had to." A complaints procedure was in place and was displayed on the home's notice board. This was only available in standard sized print, which some people would have struggled to read, but the registered manager told us they were planning to make it available in a more accessible format..

Requires Improvement

Is the service well-led?

Our findings

At our last comprehensive inspection, in August 2017, we identified breaches of Regulations 17 and 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to operate effective quality assurance systems and had failed to display their performance rating on the premises or on their website. At this inspection, we found some action had been taken, but there was a continuing breach of Regulation 17 as quality assurance procedures were still not robust.

The quality assurance process consisted of a range of audits, together with monitoring visits by a representative of the provider. However, there was no system in place to audit people's care plans. Care plans were reviewed monthly by nominated key workers, but the reviews had not identified or addressed the lack of key information in some people's care plans. This included the failure to update people's risk assessments after they had fallen; the lack of a nutritional care plan for one person; the lack of a catheter care plan for another person; and a lack of information about people's end of life wishes.

The medicines audit had not identified that the medicines fridge temperature was too low or that risks assessments for people using blood thinning medicines had not been completed. A health and safety audit in January 2018 had identified that the provider did not have a process to check the health status of new staff, but this was not addressed until we identified the concern during the inspection.

The provider had responded to all issues identified in the last inspection report and responded promptly to all issues identified during this inspection. However, the range of issues identified demonstrated that the quality assurance systems were not yet operating effectively.

The failure to operate effective systems to assess, monitor and improve the service was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other audits we looked at had been more effective in bringing about improvement. For example, an infection control audit has had identified the need for additional cleaning in the shower and a subsequent audit confirmed this had been done. Another audit had identified the need for an electrical check of appliances and we saw this had been booked.

The provider had significantly enhanced their oversight of the service since the last inspection. The registered manager told us that one of the directors of the provider's company visited regularly. Another representative of the provider visited monthly to monitor the service. They completed records of their visits and details of any action that was needed; these related to management issues and the running of the service, rather than to people's care. However, the provider had also engaged the services of a registered nurse to provide advice and guidance about care provision. This work had only just started, but included plans to audit people's care plans to ensure they were fit for purpose. The registered manager told us the extra support had been "brilliant" and had helped them in their role. They were further supported through links with a registered managers association and by one of their peers with a background in training who provided ad hoc advice.

People told us they enjoyed living at Victoria House and felt it was run well. One person said of the home, "It's run like a very good hotel." Other comments from people included: "I don't think I could find a better home" and "I would definitely recommend [Victoria House]. It feels like home". A family member echoed these comments and added, "Everything is organised very well." A social worker who had contact with the home told us, "I have found the [registered] manager to be very supportive of residents' wishes."

Staff spoke enthusiastically about their work and said morale had improved significantly since the last inspection. Comments from staff included: "Everyone knows what's happening and it's more organised. We had a staff meeting where we were all able to have our say and things got better after that"; "Morale is better now and I feel happier coming to work" and "There's good team work. We look out for each other and make sure people get the care they need". All staff expressed a shared commitment to supporting people to the best of their ability. The registered manager sought feedback from staff during regular staff meetings, but staff said they could "chat with [the registered manager] every day" as their door was "always open".

The provider sought feedback from people. The registered manager maintained open communication with people and were readily available to discuss any concerns. In addition, key workers used their monthly 'talk time' sessions with people to seek feedback about the service and any changes they wished to see in the way it operated. The provider sent questionnaire surveys to family members every year and attended occasional meetings with friends and family members to seek their feedback.

People and relatives described an open and transparent culture within the home. Friends and family members could visit at any time. One family member told us, "We are always made welcome and get offered tea. We could even stay for lunch if we want." To keep people and family members informed, a senior staff member had started producing monthly newsletters about events at Victoria House, including planned trips, activities and staff changes.

Providers are required to notify CQC of significant event to enables CQC to monitor the service and take regulatory action when needed. Whilst CQC were usually notified of significant events at Victoria House, we identified one incident which had not been notified. However, the registered manager made the notification retrospectively and changed an incident check sheet they used to prompt them to notify CQC in the future. The home's previous inspection rating was displayed prominently in the entrance hall and on the provider's website. A duty of candour policy was in place. This required staff to act in an open and transparent way when accidents occurred and to provide information and an apology in writing to the person or their relatives. We saw an example of where this had been followed.

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 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate effective systems to assess, monitor and improve the service. Regulation 17(2) (a).