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Victoria Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 6 and 11 July 2016. The first day was unannounced which meant the registered provider and staff did not know we would be visiting the service.

At the last inspection on 20 and 26 October 2015 we found the service was not meeting all the requirements of the Health and Social Act 2008. There were gaps in the records of maintenance and safe systems were not in place for hazardous substances. We also found that safe staffing levels were not in place and training was not up to date. The service had no registered manager in post and quality assurance processes were not regularly completed therefore the service did not show good governance. Some records were inaccurate or incomplete.

Victoria Lodge is a large converted terraced house in the centre of Saltburn. The service can provide care and support for up to fourteen adults who have a mental health condition. At the time of inspection only eleven people were living at the service. The service is close to all local amenities. It is located on a quiet residential street and services are provided over three floors. There is a rear courtyard and on street parking.

The home has not had a registered manager in post since 27 February 2015. 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 a 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 time of the inspection the registered provider was supporting the service on a day to day basis.

Safeguarding alerts had been made when needed. Staff understood the procedure they needed to follow if they suspected abuse might be taking place.

Risk assessments were in place for people who needed these and they were specific to people's needs and were regularly reviewed. Staff understood that people could take reasonable risk.

Emergency procedures were in place for staff to follow and personal emergency plans were in place for everyone. A new robust procedure for recording fire drills had been implemented.

Robust recruitment procedures were in place and appropriate checks had been made for newly recruited staff.

There were sufficient staff on duty. People told us there was enough staff on duty day and night to meet their needs. A dependency tool was used to determine safe staffing levels.

Medicines were managed appropriately. The service had policies and procedures in place to ensure that medicines were handled safely. Medication administration records were completed fully to show when

medicines had been administered and disposed of. However, there was no clear record within the medication administration records, of where creams should be applied

Certificates were in place to ensure the safety of the service and the equipment used. Maintenance and fire checks had been carried out regularly by the service. However the stair lift service maintenance certificate was not up to date. The registered provider has since taken action to correct this.

Staff performance was monitored and recorded through a regular system of supervision and appraisal. Staff had received up to date training to support them to carry out their roles safely and had completed an induction process with the provider. People told us they felt staff had the knowledge and skills needed to care for them.

People were supported to maintain their health. People spoke positively about the nutrition and hydration provided at the service. Staff understood the procedures they needed to follow if people became at risk of malnutrition or dehydration.

Some staff demonstrated good knowledge and understanding of the requirement of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and knew what action they would take should they suspect a person lacked capacity. However, documentation was not always in place to support best interest decisions.

Each person was involved with a range of health professionals and this had been documented within each person's care records. From speaking with staff we could see that they had a good relationship with the health professionals involved in people's care.

People told us they could spend time with other people in the lounge area or spend time in private if they wished. During our inspection the lounge space was able to accommodate those people who wished to use it. People had spacious bedrooms which included their personal possessions.

People spoke highly of the service and the staff. People said they were treated with dignity and respect.

People, and where appropriate their relatives, were actively involved in care planning and decision making; this was evident in signed care plans. Information on advocacy was available should it be needed.

Care plans detailed people's needs wishes and preferences and were person centred. People's life history was documented. Care plans were up to date and regularly reviewed.

There was no evidence of any planned activities taking place on the day of inspection. People had been on day trips to Whitby and other day trips were in the process of being planned.

The registered provider had a clear process for handling complaints. There had been no complaints received in the last twelve months.

Staff told us they enjoyed working at the service and felt supported by the registered provider. Staff told us they were confident any concerns would be dealt with appropriately. We could see from our observations and from speaking to people and staff that the registered provider had a visible presence at the service.

Quality assurance process were in place however these lacked detail and it was unclear from the documents we looked at what areas had been audited and what actions had taken place as a result.

Accidents and incidents were monitored to identify any patterns and appropriate actions were taken to reduce risks. However the recording of falls was difficult to audit and monitor if any trends were occurring.

Feedback from staff and people who used the service was not regularly sought. Meetings had taken place regularly but surveys had not been distributed for a long period of time. The registered provider took immediate action to correct this and action plans have been developed as a result.

The service worked with various healthcare and social care agencies and sough professional advice to ensure that the individual needs of the people were being met.

The registered provider understood their role and responsibilities. Notifications had been submitted to CQC in a timely manner. Notifications are documents about changes, events or incidents the provider is legally obliged to send us within required timescales.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service is safe.

Risk assessments were in place for people who needed these. They were specific to people's needs and regularly reviewed.

Safeguarding alerts had been made when needed. Staff understood the procedure they needed to follow if they suspected abuse might be taking place.

Emergency procedures were in place for staff to follow and personal emergency plans were in place for everyone.

Medicines were managed appropriately. The service had policies and procedures in place to ensure that medicines were handled safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff performance was monitored and recorded through a regular system of supervisions and appraisals.

Staff had not received training in specialist areas.

Some staff demonstrated good knowledge and understanding of the requirement of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, documentation was not always in place to support best interest decisions.

People were supported to make choices in relation to their food and drink.

The staff worked with other professionals to support and maintain people's health.

Is the service caring?

Good

The service was caring.

People spoke highly of the staff and said they were treated with

dignity and respect.

Staff were very knowledgeable about the likes, dislikes and preferences of people who used the service.

Care and support was individualised to meet people's needs.

Is the service responsive?

Good

The service was responsive.

People who used the service, and where appropriate relatives, were involved in decisions about their care and support needs.

People's preferences and needs were reflected in the support they received.

People who were independent were able to access a variety of activities of their own choice. People who needed support in this area did not have much activity to choose from.

A robust procedure was in place for managing complaints. People we spoke with knew how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was no registered manager in post.

Quality assurance processes were in place and completed monthly. However they lacked detail regarding what actions had taken place as a result of the audits.

Feedback from staff and people who used the service was not regularly sought.

Staff told us they felt supported and included in the service by the registered provider.

Victoria Lodge

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 6 and 11 July 2016 and the first day was unannounced which meant the staff and registered provider did not know we would be visiting. We informed the registered provider of the date of our second visit. The inspection team consisted of one adult social care inspector.

Before the inspection we reviewed all the information we held about the service which included recent notifications submitted and we spoke with the local authority contracts and commissioning team. The registered provider had not been requested to complete a provider information return (PIR).

At the time of our inspection there were eleven people who used the service. We spoke with four people who used the service and one relative. We spent time in communal areas and observed how staff interacted with people. We looked at all communal areas of the home and some bedrooms with people's permission. We spoke with four staff members including the registered provider, two senior carers and a cook.

During the inspection we reviewed a range of records. This included two people's care records and eleven people's medication administration records. We also looked at three staff files including recruitment, training records, supervisions and appraisals, records relating to the management of the home and a variety of policies and procedures.

Good

Is the service safe?

Our findings

At the last inspection we found there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to safe staffing levels. Staffing levels were inadequate for the level of support that was needed for people who used the service. The registered provider had included themselves in the staffing numbers but was unable to provide personal care or administer medication.

At this inspection we could see that the registered provided had taken action to correct this. A dependency tool was now being used that assessed the individual needs of each person who used the service. Areas that were looked at included eating, moving, personal care, medication and toileting needs. Each area was scored in accordance with the persons needs and then a total dependency score calculated. Staffing levels were then set according to people's dependency levels. We could see that people were independent with most tasks and needed minimal support. One senior carer and one care assistant were on duty during the day and one care assistant and one senior were on duty during the night. The registered provider was present during the day but was not including in staffing numbers. These staffing levels were sufficient to meet the needs of the people who used the service. People we spoke with confirmed this. One person said, "There is always someone here when I need any help, I have never not been able to get help when I have needed it."

At the last inspection we also found there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to safe care and treatment. The service was not planning to ensure people were safe. People who used the service were able to leave the home freely and independently. People did not communicate where they were going or when to expect them back and staff were not observed to ask people about this. No risk assessments were in place to minimise the risk in this area.

At this inspection we could see the registered provider had taken action to correct this. Risk assessments had been developed for people who regularly accessed the community independently. We also saw evidence of a weekly planner which detailed where the person would visit, which day the visit would take place and the usual times of leaving the home and time of return. Staff we spoke with were able to give details of which people regularly accessed the community independently and the days which this occurred. One person who used the service had been given a mobile phone. The registered provider's contact details had been printed out and stuck to the back of the phone so if the person needed to contact the home they could. This meant the home could also contact the person throughout the day to check they were safe. Meetings between the people who used the service and the registered provider had also taken place to discuss accessing the community and the importance of people notifying staff if they were planning on going into the community independently. We saw minutes of the meetings to confirm this.

We asked people if they felt safe living at the service. Everyone spoken with confirmed they did. One person said, "I know I am safe here. I feel better living here than I would living on my own." One relative we spoke with told us, "I know [relative] is safe here. [Relative] certainly seems to like it and I visit regularly and have

never had any concerns." One staff member told us, "People are definitely safe and if they didn't feel safe we would do something about it."

All staff spoken with had a good level of knowledge and understanding of safeguarding and the different types of abuse. They were able to tell us the procedure they would follow should they suspect abuse. An up to date safeguarding g policy was available and people who used the service had safeguarding advice printed and displayed on the back of their bedroom doors.

Staff told us they would not hesitate to whistle blow (tell someone) regarding any concerns they had. One staff member told us, "I am confident that anything I report would be dealt with correctly and kept confidential." Another staff member told us, "I would definitely report anything I didn't think was right. We are here to care for people so I would do anything to make sure that is what we are doing."

Risk assessments were in place associated with the day to day running of the service. Regular checks were made of areas such as water temperatures, emergency lighting and fire alarms. Required maintenance certificates were in place for areas such as fire alarms, electrical testing and legionella. However, the stair lift at the service had not been recently maintained. We spoke to the registered provider about this who took action immediately to correct this. Specific risk assessments for people's individual needs were also in place where required. These included falls, moving and handling and nutrition. We could see these risk assessments had been regularly reviewed and updated when needed.

We looked at arrangements for managing accidents and incidents and what actions were taken to prevent reoccurrence. Records were in place to show that accidents and incidents were reviewed on a monthly basis. From records we could see that one person had suffered a number of falls over a two month period. Action had been taken such as contact with and visits from the GP, social worker input and a nursing assessment had taken place. As a result of the action taken the person was transferred to a nursing home as their needs had increase. We could also see evidence of the falls team being contacted for two other people who used the service as a result of the accidents and incidents being reviewed. However, staff were using a note book to record falls. We found this information was difficult to audit and check how many falls a person had suffered and if there were any trends of falls over a period of time.

Personal emergency evacuation plans (PEEPS) were in place for each person who used the service. PEEPS provide staff and emergency services with information about how they can ensure an individual's safe evacuation from the premises in the event of an emergency. The PEEPS contained information including what assistance would be required and other considerations such as medical condition that would need to be considered to evacuate someone safely. We could see that the PEEPS were reviewed and updated as needed.

We looked at records that showed a recent fire drill had taken place in July 2016. A new recording document had been developed and information now detailed the date and time of the drill, names of participants, time taken to evacuate the building and an evaluation of the fire drill and any areas of improvement.

During the inspection we looked at three staff files. Recruitment records looked at had completed applications and interview questions in place. Two references and a Disclosure and Barring Service (DBS) check had been sought prior to two of the staff starting employment at the service. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and vulnerable adults. One of the staff files that we looked at evidenced that the person had started working at the service before their DBS had been received.

We spoke to the registered provider about this who told us the person had been recruited in 2009 and recruitment procedures had been improved since this time. The other two staff files we looked at confirmed this.

Systems were in place for the safe management of medicines. People's use of medicines was recorded using medicine administration records (MARs). A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. Each person's MAR contained their photograph, any known allergies and details of the medicines they were using and how they should be administered. This helped to ensure people received the right medicines.

We reviewed eleven people's MARs and saw that there were no gaps in administration. Where medicines had not been administered the reasons for this had been recorded. A list of staff signatures for those staff administering medicines was stored at the front of the MARs. This helped create a clear record of who was administering medicines.

MARs were used to record the use of topical medicines such as creams. These included details of how much of the medicine should be applied and frequency, for example. 'Apply thin layer three times daily.' However, there were no details of where the topical medication was to be applied. No body maps were in the MARs record so it would be difficult for staff administering the topical medication to know where the medication was to be applied. We discussed this with the registered provider who told us that body maps are included in the persons care plan which staff can refer to when applying topical medication.

Medicines were stored securely in a locked medicines trolley. When they were not being used for medicine rounds these were stored securely in a locked room. The temperature of the medication storage room was monitored and recorded on a daily basis.

Stock checks of medicines were carried out every month to ensure people always had access to the medicines they needed. Surplus medicines were securely stored until they could be returned to the pharmacist for disposal. There was no person using the service who was prescribed a controlled drug.

We observed a member of staff administering medication. Staff supported this person at their own pace and explained what medicines they were taking. People were given choice over whether or not they wanted their medicines.

On the second day of inspection we saw staff completing their daily audit of medication and they reported an error they found whilst completing this audit. Appropriate action was taken by the staff member and the registered provider told us the action they would take to ensure the person was safe and to prevent reoccurrence.

The service had a medication policy in place which staff understood and followed.

Communal areas and bathrooms were clean and tidy. Cleaning equipment was securely stored when not in use in a locked cupboard. On the first day of inspection we identified that a window in one of the bathrooms had a large crack in it. We discussed this with the registered provider and asked that this was attended to as soon as possible. On the second day of our inspection we were told a contractor had visited the service and the window was due to be replaced within three days.

Requires Improvement

Is the service effective?

Our findings

People we spoke with and their relatives thought staff were suitably trained to look after them. One person told us, "The staff here know everything and they know me." Another person said, "I think they are all great. They all seem to know what they are doing. I have never had a problem."

We asked staff to tell us about their induction, training and development opportunities they had been given at the service. Staff told us, "We have done a lot of training recently just to refresh. I enjoyed it, it's always good just to refresh but I am confident I have all the training I need to do my job correctly." Another staff member said, "I have been here years and I have always had training. We have worked hard to make sure all training is up to date following the last inspection." The registered provider told us, "We have tightened our belts with training. All training is now up to date."

We looked at a training matrix which confirmed training was up to date in areas such as safeguarding, first aid, infection control, MCA & DoLS, health & safety and fire safety. However, of the ten staff members who administered medication, only seven had up to date training in this area. Medication competency checks had been completed within the past six months for all staff administering medication to say they were safe to administer medication. We could see no evidence of training in areas such as mental health, person-centred care or specialised courses. The registered provider told us there was plans for further fresher training in areas such as medication throughout the year.

Staff were supported with regular supervision and appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. Staff generally received four supervisions a year and an annual appraisal. Supervision took place more frequently if concerns had been raised. Records of these meetings confirmed they were used to discuss any support needs the member of staff had, as well as confirming their knowledge of the registered provider's policies and procedures. Records we looked at confirmed that supervisions and appraisals were up to date.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 make particular decisions, any made on their behalf must be in their best interests and least restrictive as possible.

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

We checked whether the service was working within the principles of the Mental Capacity Act.

The registered provider and staff that we spoke with told us that they attended training on Mental Capacity Act (MCA) 2005. Some staff were able to demonstrate their knowledge. However, one staff member we spoke with told us, "There is no one here that lacks capacity." We could see that one person had their money

managed by the local authority. However, there were no records about when the person was deemed as lacking capacity in this area or that it was in the person's best interests to have their money managed for them.

At the time of our inspection, no people who used the service were subject to a Deprivation of Liberty Safeguard (DoLS) order.

Staff we spoke to had a good level of understanding with respect to people's choices and consent. We could see that consent to care had been given by people or, where appropriate, their relatives and signed documentation was present in care plans to evidence this. This documents covered areas such as consent to treatment, sharing information and consent to photographs being taken.

People who used the service had not made advanced decisions on care and treatment. No one using the service had a 'do not attempt cardio-pulmonary resuscitation' (DNACPR) currently in place.

People were supported to maintain a balanced diet. People weights were monitored and recorded on a monthly basis. People were assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults are malnourished or at risk of malnutrition. People's weights were monitored in accordance with the frequency determined by the MUST score, to determine if there was any incidence of weight loss. This information was used to update risk assessments and make referrals to relevant health professionals if needed.

Staff were able to tell us whether the people they supported had specific dietary needs and if so what they were. People's dietary needs and preferences were displayed in the kitchen and the cook was able to describe how these were met. The registered provider supplied the service with a menu that had been developed with the input from the residents and cook. The cook said they were free to adapt this to meet people's preferences. A cook that we spoke with told us, "We do a lot of home cooking and baking here – scones, birthday cakes and biscuits. That is what the people want. They enjoy a good home cooked meal. We have quite a few people who will often request different things other than what is on the menu which is fine. We have also just recently changed the menu to a summer menu. It all seems to be going down well."

We looked at the menu plan. We could see that there was a four weekly rolling menu. Two meal options were available at each meal times and people were asked to select what they would like for lunch and evening meal after breakfast each day. People we spoke with told us that they were able to select a different option if they preferred.

We asked people about the food. One person said "Its ok, it could be better. We have a say in what we want though." Another person told us "The food is good. I don't always want what they have on the menu but I just tell them what I want and they sort it for me. They add extra items that we ask for to the shopping as well. My family bring me in some foods as well."

We saw that people were able to eat at flexible times. People independently prepared snacks and breakfast and assistance was available from staff if needed. The kitchen was equipped so people could use facilities independently. Throughout the day the dining room was pleasantly presented with condiments and cutlery readily available. People spent time in the dining room throughout the day taking part in activities such as board games and jigsaws. We saw that staff were available to offer assistance when needed.

Care records contained evidence of close working with other professionals to maintain and promote people's health. These included GPs, district nurses, the local mental health team, social workers and

dieticians.

We could see that the building was in need of some repairs and the décor updating. The registered provider told us about plans to decorate the lounge area and some repair work had already been completed. Some of the flooring had been replaced and some of the communal rooms had been redecorated.

Good

Is the service caring?

Our findings

People who used the service told us they were very happy and staff were caring. One person said, "They are all lovely. They do look after me well." Another person said, "I can't really say anything bad about the staff. There is nothing to complain about really. I like the staff – they are very good."
A relative told us, "They know the people who live here very well. I have never had a problem with the care. They are all very caring and [relative] is very happy here."

During the inspection we spent time observing staff and people who used the service. One the first day of inspection we saw one person getting her hair dyed by a staff member. The staff member explained kindly what she was doing and checked the person was happy with the colour the person had chosen themselves. The staff member explained that the person enjoyed getting their hair dyed and this was something that was done every couple of weeks. The person told us, "I love to get my hair done and [staff member] does it the best." The staff member and person who used the service spent time chatting and laughter could be heard coming from the room.

We saw staff were respectful and called people by their preferred names. Staff were patient with people when speaking to them and took time to ensure people understood what was being said. Staff members often approached people who used the service to check they were ok and had general chats about the person's day and what their plans were for the coming weeks. Staff explained to us how they respected a person's privacy and dignity, such as keeping curtains and doors closed when assisting people with personal care and by respecting people's choices and decisions.

We saw one person who was escorted to a doctor's appointment. The person was approached and asked if they would prefer to walk to the surgery or to be taken in a car. The person was also given preference as to which staff member they would like to assist them.

Care plans detailed peoples wishes and preferences around the care and treatment that was provided. We could see evidence, such as signatures in care plans, that people were being involved in care planning and in some situations relatives had also been involved. Relatives we spoke to confirmed that they were involved in their relatives care needs.

We observed staff seeking people's permission before any care and treatment was provided to people and people we spoke with confirmed this. One person said, "I like to spend time in my room. The staff always knock and wait for me to open the door, they never just walk in." We saw that one person had received some fresh fruit from a relative. A staff member approached the person and asked if they would like them putting in the fridge. Permission was given and the staff member stored the fresh fruit in the fridge. The staff member then returned to the person to inform them where they had been stored in the fridge.

We observed that people were directing their preferred routines both at the home and accessing the community. We saw one person leaving the home independently to participate in charity work. The person using the service told us, "I go out every day and collect for a charity. I have always had the support of staff. I

am dying my hair in the next couple of weeks for charity and the staff have helped me plan this."

People spent their recreational times as they wanted to and had access to communal areas as well as private space if they wished. We saw that people were able to go to their rooms, as they wished, throughout the day. People had open access to an outdoor courtyard where a smoking area had been developed. People chose when they wished to rise on a morning and retire on an evening and people we spoke to confirmed this. This helped to ensure people received care and support in the way that they wanted. One person said, "I get up when I want really. I normally spend a couple of hours in my room on a morning watching TV. I usually have my breakfast in my room too."

It was evident from discussions with staff and the registered provider that all staff knew people well, including their personal history, preferences, likes and dislikes. One staff member said, "I have been here for over ten years. These people are like my family. I know them all inside out really."

People who used the service had access to independent advocates. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them. The registered provider told us that there was no one who used the service that was currently using an advocate. Staff were aware of the process and action to take should an advocate be needed.

At the time of the inspection there was no one receiving end of life care, however information on people's wishes and preferences was documented in their care files.

Good

Is the service responsive?

Our findings

During our inspection we looked at two care plans. Care plans began with a 'personal profile'. This contained a photograph of the person and detailed the person's personal details such as date of birth, previous address, marital status, doctors and social worker details as well as a detailed description of the person including hair and eye colour. A 'life history' document had also been developed. This detailed what was important to the person and how best to support them.

Care plans were produced to meet individual's support needs in areas such as communication, mobility, eating and drinking, personal hygiene and emotions. Care plans were detailed and focused on the person's preferences and were reviewed monthly. Care plans that we looked at were up to date and met the person's current needs. We saw that one side of the care plan document reflected the opinion of the person being supported and the reverse described the plan of care from a staff members perspective. One care plan detailed a person's emotions and that they preferred privacy. As a result a cordless telephone had been purchased to allow the person to speak with relatives in private as this was their preferred method of communication. Another person's emotional care plan detailed signs of 'unwell' behaviour, the specific triggers that staff should be aware of and action to take should they suspect 'unwell' behaviour.

We discussed how people's finances were managed. Some people requested the registered provider to keep money for them. Care plans detailed peoples preferences with regards to finance. Where people had made the decision for the registered provider to hold their money, signed documentation to consent to this was evident in care files.

We spoke with staff who were extremely knowledgeable about the care that people received. Staff were responsive to the needs of people who used the service and people and relatives that we spoke with confirmed this. One person told us, "I know they (staff) always do what is best for me. They know when I am not well and know what to do to keep me safe."

During the inspection we saw little evidence of planned activities taking place. Many of the people who used the service accessed the community independently and visited local shops. We saw people being escorted to appointments and to see family. Board games, reading materials and quizzes were available throughout the home and we saw that some people enjoyed playing board games with staff members and the registered provider. One person spent a lot of time alone watching TV in the lounge area. The person told us, "I like to watch TV in the lounge and it is usually quite during the day. I don't really like activities but [registered provider] has got some crochet materials for me to have a go at that, as I used to enjoy it."

People told us that day trips were planned and they were looking forward to trips to garden centres and Whitby when the weather improved. We spoke to the registered provider about activities. They told us that they were in the process of purchasing a vehicle so they could provide more day trips. This had been something that had been discussed with people who used the service at 'resident' meetings and suggestions had been made of places they would like to visit. We saw minutes of the 'resident' meetings to confirm this.

People told us they knew how to complain. One person told us, "I don't really complain. If I am not happy I speak to the staff. They are all very good and everything is sorted straight away." Another person told us, "The staff are always asking if we are ok and if I am not I tell them. We are a good group really, we all get on. I don't really have any complaints but I know what to do if I did."

The provider had a complaints policy in place which gave details about who to contact should they wish to make a complaint and timescales for actions. Information on how to make a complaint was displayed around the home as well as on the doors of all bedrooms within the home. We looked at the complaints record for the last 12 months. We could see that no complaints had been made. A system to analyse complaints had been developed that could be used to learn from complaints and record actions taken as a result. Although this system had not been used due to no complaints being received, we could see that the provider had procedures in place.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we found there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to good governance. The quality assurance policy was dated December 2014 and did not outline robust systems and processes that needed to be in place. The audits were of a checklist/tick box nature and did not describe what was being checked. Not all audits had been carried out in the required timescales.

At this inspection we could see that quality audits were in place and had been completed monthly in areas such as health & safety, medication, training and infection control. However, these were still of a tick box nature and did not describe fully what was being checked. The quality audits contained no action plans or completion dates. We spoke to the registered provider about this who was able to show us a 'maintenance book' that was used to record any actions required as a result of the quality audits. We could see that action had been taken when issues had been detected such as replacement batteries in smoke alarms. However, on the first day of inspection we identified that there was a cracked window in one of the bathrooms on the first floor. The quality audits had failed to detect this. We discussed this with the registered provider who took action to replace the broken window and resolved to use the audit system more effectively.

There had been no registered manager in post since February 2015. One of the providers had been managing the service with support from a senior carer who had been employed at the service for 15 years. There had been three people appointed as manager since February 2015 to date but none had applied to become registered managers and left the service. The registered provider told us that they were actively recruiting a registered manager. During the inspection we saw that a potential manager was completing a trial period at the home.

We are dealing with this breach of condition of registration outside the inspection process.

The registered provider recognised that a manager was needed for the service. They were also aware that failure to have a registered manager is a breach of their registration conditions and they assured us they were being proactive in seeking to fill this post.

People who used the service spoke positively about the registered provider. We could see that the registered provider had a visible presence at the home and regularly interacted with people. There was a small management office on the ground floor at the back of the building. During the inspection we saw that the registered provider spend most of their time with the people who used the service and the staff. One person told us, "Oh I love [registered provider]. I have lived here years and [registered provider] knows me through and through. We are like a little family." It was clear that the registered provider was familiar with all the people who used the service and relatives that came to visit.

Staff told us that the registered provider supported them. They told us if they had any concerns they had no problem approaching the registered provider and they were confident any concerns would be dealt with appropriately. One staff member told us, "I get regular support. [Registered provider] are good to work for.

They support us and are here all the time." Another staff member told us, "I think this is a good home and I know [registered provider] have worked hard to improve since the last inspection. I certainly get all the support I need."

Staff told us the morale was improving at the home. The registered provider had a sister home which had recently closed. As a result staff had moved from the closed home to Victoria Lodge along with some of the people who used the service. Staff told us that people had settled well and staff were beginning to settle and be more familiar with the home. Staff told us that they were kept informed about changes and were able to suggest areas for improvement to develop the service.

The registered provider investigated safeguarding alerts and accidents and incidents in a timely manner and informed the local authority and CQC when needed. Safeguarding and accidents and incidents had been thoroughly recorded and any action taken as a result had been accurately recorded by senior staff and the registered provider.

We saw that regular staff meetings had taken place with the most recent meeting taking place in March 2016. The minutes of the meeting showed that staff had the opportunity to raise concerns and be involved in decisions about the service. Areas that were discussed included medication, infection control, activities, breaks and recruitment. Minutes of the meeting were available for staff who were unable to attend the meeting to view. Regular resident meeting had also taken place. People were given the opportunity to discuss areas such as the menu, activities and trips out. We could see that requests that people had made were listened to and changes to menu's had been made as a result, for example.

During our inspection we look at feedback that was sought from staff and people who used the service. Resident questionnaires had been completed and returned but no date was available as to when these had been completed. We spoke to the registered provider who confirmed it had been early in 2015 that they had been completed. No evaluation or action plan had been produced. Staff questionnaires had not been distributed recently and the registered provider was unable to locate the most recent staff questionnaires. The registered provider took immediate action to address this and was able to submit evaluations and action plans after the inspection.

From discussions with the registered provider we could see that continuous improvements were being made and people who used the service were at the centre of this. We could see that staff had taken appropriate action to raise concerns and the registered provider ensured CQC and the local authority were notified in a timely manner of incidents which occurred at the service.