Dukeries Healthcare Limited

Victoria Care Home

Inspection report

Memorial Avenue
Worksop
Nottinghamshire
S80 2BJ

Tel: 01909476416
Website: www.dukerieshealthcare.co.uk

Date of inspection visit:
06 June 2018

Date of publication:
12 July 2018

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

Summary of findings

Overall summary

This unannounced inspection took place on 6 June 2018. Victoria Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single packages under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Victoria Care Home is registered to accommodate up to 93 people in two buildings, divided into four units. The Camelot unit provides residential care. Lancelot unit provides residential care to people with dementia. Guinevere unit provides nursing care. Champion Crescent and Flats provide support for people with an alcohol related brain injury. During our inspection, 57 people were using the service.

The service had a registered manager at the time of our visit. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection in December 2017 we identified improvements were required to ensure the quality and safety of people's care at the service. For example, people were not always kept safe from abuse or avoidable harm; people rights were not protected under the Mental Capacity Act 2005 and complaints were not always captured or responded to appropriately. We found multiple breaches of Regulations. The service was rated as Inadequate.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. Following the last inspection, we met with the provider to confirm what they would do and by when to improve the quality and safety of the service. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures. Following this inspection the service was rated as Requires Improvement.

Risks to people's health and safety had been assessed. However, further improvements were required to ensure that equipment people needed was provided in a timely manner and sufficient guidance about how to keep people safe was provided to staff. People were supported by sufficient amounts of staff who had been recruited safely. Staff understood their responsibility to protect people from the risk of abuse and what action to take if they suspected abuse. People received their medicines safely and lived in a clean home.

People were supported by staff who received training and support. An assessment of people's needs was carried out before they moved to the home. People were supported to eat and drink and the advice of external health professionals was sought when needed. People lived in a building which met their needs. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the home supported this practice.

People were supported by staff who were kind and compassionate. Staff knew people well and took time to understand their needs and wishes. People were involved in planning and reviewing their care and had access to independent advocacy. People could be assured that their privacy and dignity were respected by staff.

People received care and support in line with their preferences. Care plans contained guidance for staff about people's needs and how these should be responded to. A range of activities were provided for people at times to suit them. People were provided with opportunities to make a complaint about their care and complaints were responded to appropriately. Staff were provided with information about how people wished to be cared for at the end of their lives.

Improvements had been made to the systems in place to monitor the quality and safety of the service. However, further improvements were required. The provider also now needs to show they can continue and sustain improvement. The provider had complied with conditions of their registration and we had been notified of certain events which had taken place in the home. People and staff told us the atmosphere of the home had improved and they had opportunities to provide feedback or make suggestions for improvement.

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 home was not consistently safe

Risks to people's health and safety had been assessed. However, further improvements were required to ensure that care equipment was provided in a timely manner and clear guidance was provided to staff.

People were supported by sufficient amounts of staff who had been recruited safely.

Staff understood their responsibility to protect people from abuse and what action to take if they suspected abuse.

People received their medicines as required and medicines were managed safely.

People lived in an environment which was kept clean.

Is the service effective?

Good

The home was effective.

People were supported by staff who received appropriate training and support.

People were supported to eat and drink and the advice of external health professionals was sought when needed.

People lived in a building which met their needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the home supported this practice.

Is the service caring?

Good

The home was caring.

People were supported by staff who were kind and compassionate.

Staff knew the people well and took time to understand people's needs and wishes.

People were involved in planning and reviewing their care and had access to independent professional advocacy.

People could be assured that their privacy and dignity were respected by staff.

Is the service responsive?

Good

The home was responsive.

People received care and support in line with their preferences. Care plans contained guidance for staff about people's needs and how these should be responded to.

People were provided with a range of activities at times to suit them.

People were provided with opportunities to make a complaint about their care and complaints were responded to appropriately.

Staff were provided with information about how people wished to be cared for at the end of their lives.

Is the service well-led?

Requires Improvement

The home was not consistently well led.

Improvements had been made to the systems in place to monitor the quality and safety of the service. However, further improvements were required. Provider needs to consistently ensure proactive, timely and sustained improvement.

The provider had complied with conditions of their registration and we had been notified of certain events which had taken place in the home.

People and staff told us the atmosphere of the home had improved and they had opportunities to provide feedback or make suggestions for improvement.

People were complimentary of the management of the home and the improvements made since our last inspection.

Victoria 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.

Before our inspection the provider had notified us about a number of safeguarding incidents when they happened at the service. At this inspection we did not look at the specific circumstances of the individual incidents because these were being investigated by relevant local authorities responsible for this. However, we did look at associated risks.

This inspection took place on 6 June 2018 and was unannounced. The inspection team consisted of two inspectors, a specialist advisor who was a nurse 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 service.

On this occasion we did not ask the provider to send us a Provider Information Return (PIR). This is a form that asks the provider information about the service, what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share relevant information with us. We looked at other information we held about the service to help us plan our inspection. This included previous inspection reports and statutory notifications. A notification is information about important events which the provider is required to send us by law. We also sought feedback from the local authority and clinical commissioning group, who commission services from the provider.

During the inspection, we spoke with nine people who used the service and one relative. We also spoke with the registered manager, deputy manager, clinical nurse lead, two unit managers, a nurse, six care workers, two domestic staff, two cooks, an activities co-ordinator, compliance manager and operations director. Following our visit we also sought feedback from two healthcare professionals who routinely visited the home.

We looked at seven people's care records, electronic medicines administration records, staff training records and the recruitment records of six members of staff. We also looked at a range of records relating to

the running of the service, such as audits and maintenance records.

We observed care and support in communal areas of the service and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

When we last visited Victoria Care Home in December 2017, we found there had been a failure to assess the risks of avoidable harm and to mitigate risks fully. People were not protected from risks associated with abuse, the environment, their health conditions and medicines because these had not been fully assessed or identified. These were breaches of Regulations 12, 13 and 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found improvements had been made and the provider was no longer in breach of regulations. However, further improvements were required to ensure that measures required to keep people safe were implemented in a timely manner.

One person's care record contained advice from an external healthcare professional in April 2018 which had not been implemented at the time of our inspection in June 2018. They had recommended that suitable equipment was used to weigh a person. We asked the registered manager about this who confirmed that appropriate scales had been identified, but these had not been ordered. They immediately agreed to order the scales. Similarly, staff had been waiting for approximately three weeks for a sensor mat for a person who was at risk of falls. The manager immediately put through the order following our feedback. This meant that although measures had been identified to help keep people safe and reduce the risk of harm, they were not always in place as soon as possible. This posed a risk to people's safety.

People's care plans contained nutritional risk assessments and guidance for staff about how to reduce any risks; such as risks from malnutrition or from choking due to swallowing difficulties. Records showed that speech and language therapists (SALT) had been involved and provided guidance if required. However, we found that staff would benefit from further guidance to ensure that SALT recommendations were fully understood and implemented. For example, we saw that one person's drink had not been thickened to a 'custard' consistency as recommended. When we spoke to staff they had different perceptions of what was custard consistency. We discussed this with the clinical nurse lead who acknowledged that clarity was needed and confirmed that additional training was being provided the week of our inspection. This meant that people were not always protected from risks associated with swallowing problems.

Staff told us about people who, because of their health condition, sometimes behaved in a way that could be challenging for others. Staff were confident and knew how to respond to people's behaviour. However, one person's daily care records showed instances when they were resistive to personal care from staff and verbally aggressive. Their care plan did not include reference to this and did not contain any guidance for staff to follow on how to respond to support the person. Although records showed that the support of external health professionals had been sought and their advice on completion of behaviour charts were being followed, their care plan had not been updated to reflect this. This posed a risk that staff may not respond appropriately. We brought this to the attention of the unit manager who provided us with an updated care plan following our visit.

Despite the above, people and their relatives told us they felt safe and that staff responded to risks to their safety. One person's relative said, "[Family member] used to fall down at home and it frightened me. [Family member] hasn't had any (falls) here since they have been using the wheel chair. They have a mat so if they

get out of bed they (staff) come."

People's care plans contained risk assessments in relation to different aspects of care which were reviewed monthly. This included nutritional risk, pressure ulcer risk, falls risk and choking risk. Staff told us they read people's care plans to understand the risks and the actions required to reduce these. Staff had signed the care plans we looked at to show they had read and understood the contents.

People were protected from other risks to their safety associated with the environment or equipment. Regular checks were carried out on equipment such as window restrictors, fire alarms, emergency lighting, pressure mattresses and hoists. We found that pressure relieving mattresses were set correctly for the person using them and people had individual hoist slings which were suitable for their needs. The provider had employed the services of an external agency to ensure people were protected from the risk of legionella bacteria. Emergency plans were in place to ensure people's safety in the event of a fire alarm or other emergency at the home.

People told us they felt safe at Victoria Care Home. One person told us, "I feel very safe here, there's nothing to worry about. They (staff) look after me very well." Another person told us, I feel safe; yes. They (staff) come in every so often to check up on me." We saw the main entrance to the home had a coded lock and visitors had to be let in. We observed staff reminding visitors to sign in.

People were supported by staff who understood their responsibility to protect people from the risk of harm or abuse. Staff told us about the signs of potential abuse and that they would report any concerns to a member of the management team. They were confident the appropriate action would be taken and were also aware of the role of external agencies, such as the local authority, in investigating suspected abuse. Information about safeguarding adults was on display in the service. Records showed that staff received relevant training and we saw this was reinforced by discussion in staff meetings.

People's care records contained body maps which were completed by staff when required, to show the site of any marks or skin damage found. A summary of how any damage had occurred and the care actions taken to reduce the risk of reoccurrence was also recorded. The registered manager was aware of their duty to report safeguarding incidents to the local authority. Records we looked at showed that relevant information had been shared with the local authority when incidents had occurred.

People told us that staff supported them to take their medicines when they needed them. One person told us, "I suffer terribly with my legs and they (staff) get me paracetamol when I need them; I get my other [medicines] regularly every day." Another person told us, "I'm on 10 tablets. They come the same time every day."

Staff were able to explain the signs they would look for when people were in pain or distress, to ensure they received their prescribed medicines at the time they needed them. We saw there were plans in place for medicines prescribed to be given only as required. People's care plans also described the medicines prescribed for them and how they preferred to take their medicines.

We observed staff administering (giving) people's medicines to them, and saw they did so safely. Staff told us and records showed that staff who were responsible for administering medicines had received training. They also had their competency regularly checked to ensure they were following safe practice. Staff were knowledgeable and confident in the use of the electronic medicines system used in the home. People's electronic medicines records included a photograph of the person to aid safe administration and a record of any relevant allergies they had. Records showed that people's medicines had been given when needed and

that if medicines were not given, the reason for this was recorded.

Medicines were stored safely and securely. We saw that medicines were stored in locked trolleys, a refrigerator when required or cupboards within a locked room. The temperature of the room and refrigerator were recorded daily and within acceptable limits and liquid medicines were labelled with the date of opening to ensure these were used within an effective time period. Regular checks were carried out of controlled drugs. Controlled drugs are medicines which require special administration and storage. This showed people's medicines were managed safely.

People and their relatives told us the home was clean. One person said, "It's very clean. I've a nice [bed] room and it's cleaned every day." A relative told us, "It's one of the cleanest [homes] I have been to." We observed the home and equipment to be clean during our inspection.

Records showed that staff received training in infection control and prevention, including hand hygiene. Staff told us they had access to sufficient amounts of personal protective equipment (PPE) such as single use aprons and disposable gloves. We saw that aprons and gloves were readily available and that bathrooms were stocked with paper towels and dispensable soap. We spoke with the domestic staff who showed us the products they used to clean equipment and different areas of the home. The cleaning cupboard was well stocked and staff told us they had the time and resources to complete their cleaning tasks. Records showed that cleaning schedules were completed. This meant staff were trained and had equipment available to maintain cleanliness and hygiene in the home.

People could be assured that safe recruitment procedures were followed. Before staff had started working at the service, a check had been carried out through the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. Records showed that two written references had been sought and that interviews had been undertaken before people were confirmed in post. This meant that the provider had taken appropriate steps to ensure staff were safe to provide people's care.

People told us that staff responded quickly to their requests for support. One person told us, "I have a button by my bed at night and I just press it and they (staff) come quickly." Another person told us, "I have a call button and they (staff) don't normally take very long; It's fine, I've never had to complain." Our observations during our visit supported what people told us; Throughout our inspection, we saw that staff responded quickly to people's call bells and requests for support.

The registered manager told they had sufficient staffing arrangements for people's care, including to cover staff sickness or absence. They told us how many staff were usually scheduled on duty each day. We looked at staff rotas which confirmed that the staffing levels identified by the registered manager were maintained. The registered manager told us they considered the needs of the people living at the service to determine staffing levels. We saw that each person's dependency needs had been assessed in the care plans we looked at. This meant there were sufficient numbers of staff to meet people's needs.

People were supported by staff who had received training on falls prevention and who understood the need to report any accidents or incidents. Records of accidents and incidents showed that staff completed an incident reporting and analysis form which identified the incident and the immediate action taken. These forms were reviewed by the registered manager, an investigation completed and actions to prevent a reoccurrence completed. We saw that incidents were analysed for trends, such as where falls had occurred and what time of day. For example, most of the falls in one month had been unwitnessed. Records showed subsequent management action that was taken from this, to ensure communal areas were monitored more

closely by staff.

We discussed an incident, which was being investigated by an external authority. The operations director told us that as a result of this incident they had changed the way that information about people's care needs was transferred between units. This meant that the service responded to accidents and incidents and implemented changes to help prevent a reoccurrence.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (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 made on their behalf must be in their best interests and as least restrictive as possible.

During our last inspection in December 2017 we found that people's rights under the MCA were not always protected. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection, we found there had been improvements in this area and the provider was no longer in breach of regulation.

The staff we spoke with showed an understanding of the principles of the MCA. Staff understood the need to obtain consent from people before they provided care and described how they would support people to make decisions by offering choices and using visual prompts. People's care plans contained evidence that people had been consulted about their preferences and how they wished to receive care and support. Mental capacity assessments and best interest decisions were documented when people did not have the capacity to make some care decisions for themselves. These were decision specific and contained information about who was consulted as part of the decision making process.

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 MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Records showed that formal applications had been made to the relevant local authority, if people were identified as potentially being deprived of their liberty and some of these had been authorised. We checked the condition attached to one of these authorisations and found this had been complied with. This meant that people's rights under the MCA were protected.

Staff had access to best practice guidance in relation to different aspects of care, treatment and support. We observed examples of this to be available in the clinical room and contained within people's care plans. For example, best practice guidance in relation to the prevention of pressure ulcers was referenced in people's care plans and understood by staff. We reviewed the care records of a person who had pressure ulcers. We saw that the staff were following the care plan initiated by an external health professional and that the ulcers had started to heal.

People were supported by staff who were encouraged by the management team to gain the skills and knowledge to provide effective care and support. The registered manager told us that an external training company was used to help ensure staff had the necessary skills and competencies as part of a thorough

care induction. Records showed that staff had completed an induction when they started working at the home.

Staff told us they received sufficient practical training in relation to caring for people with complex needs. This included moving and handling, safeguarding adults and falls prevention. Staff were able to access additional training in relation to people's specific needs. For example, a unit manager told us that some staff who worked on their unit had attended a five day course which was dedicated to supporting people with an acquired brain injury. We spoke to the registered manager about how they ensured that staff completed training, which the provider had identified as being mandatory within a reasonable timeframe. They told us they were aware that some staff had not completed all of the mandatory training and told us of the support they gave to staff including dedicated time and access to work computers. This meant that staff were supported to gain the knowledge required to carry out their roles.

People were complimentary of the quality of the food they received. One person told us, "The food is very nice. You have a choice of two but it is very good all the time." Another person told us, "The food is very nice and if there's anything that you don't like or don't fancy, you've only got to ask and they'll do something different for you." We saw that people were given a choice of meal, reminded of which meal they had previously chosen and offered alternatives if they wanted to change their mind, or were not eating their meal.

We observed people were provided with support and encouragement to eat their meal if required. Some people required the physical assistance of staff to eat their meals and we saw that staff provided this patiently and respectfully. The food was well presented and looked appetising. One of the cooks came into the dining area to ask people if they had eaten enough and if they were happy with the food. People were complimentary of the meal. Throughout our visit we saw that people had access to drinks and snacks and we saw jugs of fresh juice in people's rooms.

The registered manager told us that mealtime champions were responsible for carrying out observations at meal times in relation to the environment, meals and staff support and identify whether any improvements were needed. We saw this taking place during our visit. We spoke to two cooks at the service who had information about people's food preferences and dietary needs and had recently attended a training course about support people to maintain good nutrition. Records showed that the advice of the GP was sought if people's weight changed and that prescribed food supplements were given when required to help people maintain a healthy weight.

People told us that staff understood their health conditions and responded appropriately. For example, one person told us, "I'm diabetic. I eat little and often and they'll (staff) bring me snacks or I'll ask; I can't see very well, I have cataracts so they (staff) set my injections up for me and then I do it myself." We observed the person was provided with the support they had described throughout our visit.

People's care records showed that advice had been sought from external healthcare professionals when required. For example, we saw that people had access to healthcare professionals such as a GP, tissue viability nurse, diabetes nurse, speech and language therapist, optician and chiropodist. Following our inspection we spoke to two external health professionals who visited people at the service regularly. Both were complimentary of the interaction they had with staff. One health professional told us that the interaction between themselves and the staff had improved greatly over the last couple of months and that staff appeared more vigilant and knowledgeable about people's needs. They told us that any recommendations they made were implemented. This meant people were supported to maintain their health in consultation with external health professionals when required.

Information was available in the event that people were admitted to hospital. This included information about any allergies, medicines they took, medical history and any specific support requirements. The registered manager told us they were also planning to use a system being introduced by local commissioners. This is the 'red bag' initiative and is designed to improve the transfer of information, medicines and personal belongings in the event that a person was transferred to hospital. This meant that systems were in place to ensure appropriate information was sent with people if they moved to another service.

People lived in a home which was purpose built and had adaptations to assist people's movement and orientation. The corridors were wide and well-lit and hand rails had been painted in a different colour to the walls to help people see them. People were provided with visual and other sensory stimulation in the form of murals and photographs and in the dementia unit there were tactile displays mounted at an appropriate height for people to touch. A unit manager informed us that the décor had been decided on by staff and people living in the home. Relevant signage was provided for people to inform them where the toilets and dining rooms were located. There were also several quiet areas off corridors with comfortable seating and tables where people could sit which were themed and contained items of memorabilia. This meant that the home had been adapted and decorated to suit the needs and reflect the preferences of the people who lived there.

Good

Is the service caring?

Our findings

At our last inspection in December 2017 we found that people were not always supported to maintain their privacy and dignity. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found there had been improvements in this area and the provider was no longer in breach of regulation.

People told us they were treated respectfully by staff who maintained their dignity when providing care. One person told us, "Sometimes they help me get washed and dressed. They (staff) don't embarrass you; they help you keep your dignity. They are very good." Another person told us, "They (staff) treat you with respect; Yes, they are very gentle. I was asked if I wanted a man or a woman (to provide support with personal care) and I said I wasn't bothered."

The home had a display system above people's bedroom doors which indicated if someone was receiving personal care in the room. This was used by staff to ensure that people's privacy and dignity were maintained. In addition we observed that staff knocked on people's doors and waited for a response before entering. We saw that people were supported to maintain a clean and smart appearance and were asked if they would like to use a clothes protector during a mealtime. This meant that appropriate measures were taken to support people to maintain their privacy and dignity.

People told us that staff were kind, compassionate and helpful towards them. One person told us, "They (staff) treat me really well; If I get depressed I can talk to staff or they'll get people on the phone for me. I had a bad spell and they helped me. They are very kind, they are caring definitely."

We observed positive social interactions between staff and people who lived at the service. Staff took the time to interact with people either by using appropriate physical touch such as holding someone's hand or giving them a hug or smiling, saying hello or waving. We observed one person cuddling a doll which appeared to provide them with comfort and enjoyment. We saw that when interacting with the person, staff acknowledged the presence of the doll and spoke to both the person and the doll. They did this in a kindly, non-patronising manner. On another occasion we observed staff giving a person positive feedback and encouragement about their appearance following a visit to the hairdressers.

Staff made a concerted effort and showed genuine interest in establishing if people were comfortable and had their needs met. For example, we heard a person talking to a member of staff. The person's speech was not clear and the staff member asked them to repeat what they had said slowly. This enabled the staff member to understand what the person was asking and we observed the staff member responded to the person's request. On another occasion, we observed another member of staff talking with a person who had difficulty communicating verbally. The staff member was crouching down to maintain eye contact level with the person whilst they endeavoured to ascertain what the person wanted.

The staff we spoke with knew the people they were supporting well. A staff member told us that they found the care plans a lot easier to navigate and that they contained information about people's history and

background. Records showed this to be the case. Care records also showed that people were given choices about how they received their care, for example, whether they wished to be cared for by male or female staff, whether they preferred a bath or shower and what time they wished to go to bed. We observed people were offered choices during our inspection such as where they would like to sit.

People's care plans contained information about how people's wishes and preferences had been ascertained. For example, some people had contributed to the development of their own care plans and had signed their agreement. Where people were not able to do this, care plans had been produced based on observations of the person and in consultation with others who knew them. We saw that letters had been sent to family members in some instances inviting them to people's formal care reviews.

People also had access to independent professional advocacy if required. The registered manager told us they considered whether people required the support of an independent advocate to speak on their behalf or represent their best interests in decisions about their care. We saw that information about advocacy was on display at the home.

People told us that staff helped them to maintain their independence. One person told us, "They (Staff) don't take my independence off me; They let me do as much as I can. They know what I can do and respect that." We observed that staff provided support in a way which allowed people to do as much as they could for themselves. For example, we saw a member of staff assisting a person who was using a walking frame. The staff member allowed the person to do what they could themselves whilst remaining close and attentive and offering support.

Good

Is the service responsive?

Our findings

At our last inspection in December 2017 we found that people were at risk of receiving inconsistent support that did not always meet with their individual wishes and preferences. This was because staff were not always provided with sufficient information to fully ensure this. We also found that complaints or concerns were not always fully investigated, and responded to. These were respective breaches of Regulation 9 and 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection, we found there had been improvements in this area and the provider was no longer in breach of regulation.

An initial needs assessment was completed with people before they moved to Victoria Care Home. We saw that each person had a range of care plans which provided information about their assessed and on-going needs. Staff told us they read people's care plans and found these to be useful and easy to navigate to find the information they needed to provide personalised care. Care plans contained detailed information about any health conditions staff should be aware of including how people's health needs should be monitored and responded to. This meant that people's care plans reflected their individual health needs.

People's care plans we looked at contained a good level of detail about how the person preferred to be supported. For example, one person's personal hygiene care plan provided information about the assistance they required, the number of staff needed, care of their dentures, whether they liked a bath or a shower and the type of clothes they liked to wear. Care records contained evidence of how people had been involved in developing their care plans. For example, by discussion with the person or by a combination of involvement of those who know the person well and staff observations. This meant that people or their families were involved in developing people's care plans.

People were regularly supported to partake in social and recreational activities at the home. Two activity co-ordinators were employed who provided a range of activities across each day. The registered manager told us they had altered the times that activities were provided following feedback from people who said they wanted more activities in the evenings. The activity co-ordinator we spoke with told us they had arranged evening activities, such as quiz nights and cheese and wine evenings in response to this.

Some of the people we spoke with told us they participated in the activities on offer and enjoyed these. One person told us, "I go out in the garden. We do all sorts, paint our nails, quiz nights, cheese and wine parties." Another person said, "We play bingo. The other night we had a 'cheese and wine do.' On Thursdays we have music games and quizzes. A vicar comes and we have songs." A third person told us they did not participate but this was their choice as they preferred to spend their time in their room.

We saw a large colourful display of the weeks activity programme in the home. This included activities such as 'chairobics', reminiscence, trips to town, quizzes and arts and crafts. People were given opportunities to access the local community and the activity co-ordinator told us they had developed links with local external agencies such as a local nursery, church and schools. During our inspection we saw an activity co-ordinator painting people's nails and talking to them about their interests, whilst they were waiting to see the hairdresser.

The registered manager told us they considered people's equality and diversity needs at the point of their assessment for admission to the home. They told us they endeavoured to ensure people were treated equally according to their needs and preferences. We saw that people's care plans contained information about people's preferences such as whether they practiced their religion or had specific needs in relation to their diet.

Although the registered manager was not fully aware of the Accessible Information Standard they showed an awareness of some of its principles. The Standard ensures that provisions are made for people with a learning disability or sensory impairment to have access to the same information about their care as others, in a way that they can understand. The operations director told us that as a company they were developing easy read care plans and would use these within the home when required. They told us no one in the home required this at present. We observed staff following people's care plans throughout our inspection to support people's communication needs.

People were supported to make decisions and state their preferences for end of life care. The registered manager told us they had invited people and their families to discuss their preferences in relation to this. Care plans recorded if people and their families had wished to discuss end of life care and if known, people's preferences. For example, some care plans contained information about people's preferred place of death and how they wished their family to be involved. The staff we spoke with showed an awareness of people's needs at the end of their life and gave examples of how they would ensure people were comfortable, for example by providing mouth care. This meant people were involved in developing their care plans.

People and their relatives told us that complaints or issues of concern were dealt with promptly and effectively. One person told us they had made complaint and that the care they were provided with had improved as a result. They said, "I put a complaint in, in writing, and it's all different now." A relative told us, "I've not really had many problems, but if I have I talk to the person that runs the shift and they try and answer me; sort it out. For example, one of the residents was going into [family members] room so they (staff) gave [family member] a key so they can lock their room now."

We reviewed six complaints, which had been received since our last inspection. These had been documented, investigated and a response provided to the complainant. Records also clearly showed whether complaints had been resolved; for example whether the complainant was happy with the response.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in December 2017, we found that people were at risk of receiving unsafe or ineffective care. This was because the provider did not operate effective systems to regularly assess, monitor and improve the quality and safety of people's care at the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection, we found there had been improvements in this area and the provider was no longer in breach of this regulation. However, further improvements were required to ensure that accurate records were kept of the care and support provided to people and clear guidance was provided to staff.

Daily recording sheets were in place for staff to record information such as people's food and fluid intake, people's skin checks and related records of their body re-positioning to alleviate skin pressure. However, we found these were not always accurately completed, despite the registered manager informing us that regular checks were carried out. For example, we reviewed three days chart's for one person and saw they had received sufficient amount to drink for their required fluid intake for two days; but on a third day only 300mls of fluid was recorded. This would not be a sufficient amount to help maintain the person's hydration. In other records we saw it was not always clearly recorded when required, whether people had been prompted to change their body position in line with their care plan or how much food they had eaten. The registered manager confirmed that changes had been made to their daily recording sheets following our inspection.

Further improvement was needed to ensure regular management checks and timely actions to fully ensure people's safety. This included, the timely provision of any care equipment required to help keep people safe; and to ensure staff understood and followed relevant care instructions from external health care professionals when required. For example, to ensure the correct consistency of people's drinks for their safety.

Improvements had been made to other checks and audits carried out within the home to help ensure the quality and safety of the service. For example, daily checks were carried out on call buzzers and window restrictors to ensure these were working. Weekly medicines audits and fire checks were being undertaken and monthly audits were being carried out in relation to care plans and infection control. This meant that whilst some improvements had been made the provider had not yet demonstrated sustained improvement over a significant period of time. We will check whether systems and audits continue to be used effectively to identify and make improvements at the service during our next inspection.

Since our last inspection we saw that improvements had been made at Victoria Care Home, which had a positive impact on people and staff. For example, regular meetings between senior staff and on each care unit had led to improved communication relating to people's care. Improvements had also been made, to ensure the safe management of people's medicines, the environment and care plans. We looked at recorded compliments from visitors to the home, which were positive about the improvements which had been made. One compliment stated, "The home has improved so much, especially during the last year. The décor is bright and cheerful and much attention has been given to the needs of dementia residents."

The provider complied with the condition of their registration to have a registered manager in post to manage Victoria Care Home. People and staff told us that the care ethos and home atmosphere had improved since the appointment of the registered manager. One person told us, "The running of the home has got a lot better; things get done straight away. The management's better; if you mention anything that bothers you it's dealt with straight away. There's a lot more banter now, a lot of laughs; It's not run as a care home now; it's a proper home. There's a lot better atmosphere; You can have a laugh and joke with the carers now." A relative confirmed this view and told us, "Since it changed managers, say a year ago, it's altered a lot; It seems friendlier; It's much better."

Staff told us that the registered manager was approachable and responsive. One member of staff told us, "I can go in (to see registered manager) and if there's a problem I know it is dealt with." Another member of staff explained that the staff team and management team had a shared purpose to provide good care and worked together to achieve this. They said, "There's more communication across the whole team. There used to be a 'them and us,' up and down split; That seems to be gone now which is nice. We're all here for the same thing; the residents; There's clarity about what we are all trying to achieve together."

We observed meetings between staff working on the different care units during our inspection. For example, we sat in on a 'tea at two' meeting which was led by a unit manager and attended by six care workers. We observed that staff members participated in the discussion and the meeting appeared a valued opportunity to share updates and information. Another member of staff gave example of a suggestion which had been made by staff in relation to improving care which had been adopted by the registered manager. This meant that staff felt able to contribute their ideas to further improve the service.

The registered manager was aware of their responsibility to notify us of certain significant events, which occur in a service, such as serious injuries or allegations of abuse. We checked our records and found that we had been notified of such events as required. The provider also supported the registered manager by maintaining oversight of the running of the home. We saw that checks and observations were carried out by representatives of the provider. For example, the compliance manager carried out checks to ensure that complaints, accidents and incidents were responded to. This meant that the provider supported the registered manager to undertake their responsibilities.

People and staff were provided with opportunities to give feedback about the home. People and their relatives were provided with opportunities to attend regular meetings to discuss daily living arrangements at the home. One person told us, "They (staff) have meetings for people and families. I go to them; they talk about the running of the home. If the residents have anything they are not satisfied with they can tell [staff]." We looked at the recorded minutes from meetings which had been held since the beginning of the year. All of these had been chaired by the registered manager and attended by both people and relatives. In addition, staff and people had been invited to complete a care questionnaire and we saw that actions had been identified to further improve the home. For example, we saw that people's suggestions for social and recreational activities in the home had been acted on.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their rating within their office and on their website.