Venetian Healthcare Limited

Victoria House

Inspection report

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Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

About the service:
Victoria House is a residential care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Victoria House is registered to provide accommodation and personal care for up to 22 people aged 65 and over with a range of physical and cognitive support needs. At the time of the inspection 17 people were living at the home.

People's experience of using this service:
● People were happy living at Victoria House. They told us their needs were met in a personalised way by staff who were competent, kind and caring.

● Environmental risk assessments had been completed however, these did not cover all risks posed by the environment. Risks in respect of the stairs or the kitchen had not been assessed.

● With the exception of risk relating to people receiving blood thinning medicine individual risks had been assessed and were managed appropriately.

● Medicines were generally managed safely and, where we identified areas for improvement the manager took immediate action. People received the personal care they required. People were involved in the development of their care plans which were reviewed regularly. Staff worked with local health and social care professionals to ensure health care needs were known and met.

● People's rights and freedoms were upheld. People were empowered to make all their own choices and decisions.

● There were sufficient numbers of staff who were well trained, felt listened to and worked well together. The manager continually considered ways to improve the service for the benefit people living there. Where we identified areas for improvement they acted immediately.

The service met the characteristics of Good overall. More information is in the full report.
Rating at last inspection: At the last inspection the service was rated Requires Improvement. (Report published 20 March 2018). The overall rating has improved.

Why we inspected: This was a scheduled/planned inspection based on the service's previous rating.

Follow up: We will continue our routine monitoring of the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was effective Details are in our Effective findings below.	**Good**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was responsive Details are in our Responsive findings below.	**Good**
Is the service well-led? The service was well-led Details are in our Well-Led findings below.	**Good**

Victoria House

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was completed by one inspector.

Service and service type:
Victoria House is a care home registered to accommodate up to 22 people who need support with personal care.

The service did not have a manager registered with the Care Quality Commission. The provider had appointed a manager in November 2018 who was in the process of registering with CQC. Once registered this will mean that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
We did not give notice of our inspection.

What we did:
Before the inspection, we reviewed information we had received about the service, including previous inspection reports, action plans and notifications. Notifications are information about specific important events the service is legally required to send to us. We also considered information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we gathered information from:

- 14 people who used the service
- Six relatives or friends of people who used the service
- Two health or social care professionals who had regular contact with the service
- Five people's care records
- Records of accidents, incidents and complaints
- Audits and quality assurance reports
- The manager and deputy manager
- The provider nominated individual
- Seven members of care staff
- One housekeeper, a maintenance staff member and a chef

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management:

- People and visitors felt risks were managed safely. Visitors confirmed they had no worries about their relative's safety.
- Most individual risks to people were assessed, recorded and updated when people's needs changed. Some people were prescribed medicines which placed them at higher risk of bleeding should an injury occur. Risk assessments and their care plans had not been updated to reflect the medicines they were prescribed or guidance for staff in respect of this. The manager told us they would address this immediately.
- Environmental risk assessments had been completed however, these did not cover all risks posed by the environment. For example, no risk assessments had been completed in respect of the spiral staircase or the kitchen which was not locked when staff were not in the immediate area meaning people could access this and items such as the gas cooker. The manager sought guidance from the provider's health and safety auditors and completed risk assessments for the environment.
- Each person had a personal emergency evacuation plan (PEEP) and staff knew what action to take in the event of a fire. In February 2019 an external consultant had completed a full fire risk assessment of the home. This had identified some action was required and the registered manager was awaiting quotes for this to be completed.
- Lifting equipment was checked and maintained according to a schedule. In addition, gas and electrical appliances were checked and serviced regularly.

Using medicines safely:

- Records of medicine administration confirmed people had received their medicines as prescribed. However, some gaps were noted in medicine administration records (MARs) relating to prescribed topical creams. Where these had been prescribed to be applied once or twice a day this had not always occurred placing people's skin integrity at risk.
- When people were prescribed 'as required' (PRN) medicines there was a lack of clear guidance for staff as to when these should be administered. For example, one person was prescribed a medicine to be administered for anxiety. This had been administered the week prior to our inspection however, it was not clear from the person's daily records why this had been required or the effects of its administration. For people prescribed 'as required' laxatives there was no individual detail as to when these may be needed. When people were prescribed two different medicines for the same need (constipation or pain relief) there was no information for care staff as to which they should administer.
- Most medicines administration records had been printed by the dispensing pharmacist. Where care staff had amended or added to these there was not always a second staff member signature to confirm the amendment.
- These areas had not been identified by medicine audits which had been completed. The manager acted

to address the issues identified in respect of medicines during the inspection. New topical creams records were introduced and additional information added to PRN care plans.
● Staff had been trained to administer medicines safely. The manager was aware of the need for staff to have their competency to administer medicines safely reassessed annually however, this had not been completed for all staff who were responsible for administering medicines.
● Otherwise arrangements were in place for obtaining, storing, administering and disposing of medicines in accordance with best practice guidance.
● People told us they received their medicines as prescribed and that they could get ad hoc pain relief such as for a headache if required.
● We observed staff administering medicines in an appropriate and safe manner.

Preventing and controlling infection:
● The laundry was well organised to help ensure clean items did not come into contact with those waiting to be washed. However, there was no separate hand washing sink for staff to use before leaving the laundry room. The manager took immediate action and requested a plumber to assess how this could be provided.
● Staff had completed initial infection control training however, records showed this was now overdue for update training.
● The home was clean and staff completed regular cleaning in accordance with set schedules.
● People and visitors felt the home was kept clean. One person told us "'I think it [the home] is very nice. Very clean."
● Staff had access to personal protective equipment, including disposable gloves and aprons, which we saw they used whenever needed. Secure facilities were available for the safe storage of waste pending its removal from the home.
● The local environmental health team had awarded the home four stars for food hygiene. The manager described the action they were taking to address the actions identified in the food hygiene report.

Learning lessons when things go wrong:
● The manager explained the action staff should take should they identify a bruise or other skin injury. This included reviewing the person's care plan and seeking medical advice when necessary. However, we found this had not been completed for one person and care staff had not informed the management team when they recorded a skin injury on a body map. This meant no action to investigate and seek medical advice had been taken.
● There was a system to record accidents and incidents. When these had occurred, appropriate action had been taken where necessary. For example, medical advice was sought, the manager undertook an investigation, risk assessments were reviewed and any lesson learnt were discussed with staff and further training offered if required.

Systems and processes to safeguard people from the risk of abuse:
● Appropriate systems were in place to protect people from the risk of abuse.
● People said they felt safe at the home. One person said, "Yes, I feel safe here, the staff are all very nice."
● Staff had received safeguarding training and knew how to prevent, identify and report allegations of abuse.
● Safeguarding incidents had been reported and investigated thoroughly, in liaison with the local safeguarding team. The manager was clear about their safeguarding responsibilities and had attended additional safeguarding training for managers.

Staffing and recruitment:
● People were supported by appropriate numbers of consistent, permanent staff.

● People told us they felt there was enough staff. One person said, "You ring and you know you only have to wait a minute or so and someone's [staff] there."
● Care staff told us they felt there were sufficient staff available and we saw people were supported without being rushed. Housekeeping staff also confirmed they had time to complete all scheduled cleaning.
● The manager told us they kept staffing levels and skill mix under review and assured us they would be increased if people's needs required this. They had identified the need to have senior staff on duty at night and two new senior night staff had been recruited.
● The provider had clear recruitment procedures in place. Records confirmed these were followed and had helped ensure that only suitable staff were employed.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
- Prior to admission to the home the manager undertook an assessment of people's individual needs to ensure these could be met including any equipment or specific adaptations that may be required. We also saw that a request was made to the person's GP for medical information and copies of this and hospital discharge documents were kept within care files. This would help ensure all needs were known and met following admission.
- Staff followed best practice guidance. For example, they used nationally recognised tools for assessing the risk of skin breakdown and the risk of malnutrition. They then acted to achieve positive outcomes for people identified as at risk.
- Staff made appropriate use of technology to support people. An electronic call bell system allowed people to call for assistance when needed; pressure-activated floor movement sensors were used to alert staff when people moved to unsafe positions. The manager was aware of how to access specific equipment such as beds and pressure relieving mattresses when people required these to meet identified care needs and risks.

Supporting people to eat and drink enough to maintain a balanced diet:
- People's dietary needs were assessed and met consistently. People were all positive about the meals they received and confirmed they were offered a choice. Relatives were also positive about the food.
- People were offered a choice of food and drink, including regular snacks. One person said "It's [the food] very nice." The person confirmed staff would always give them an alternative if they did not like what was provided.
- People's weight was regularly monitored and the manager described the action they would take should a person lose weight. The manager was unable to establish when the homes weighing scales had been recalibrated to ensure an accurate reading but undertook to ensure this occurred.
- We saw, where needed, people received appropriate support to eat and were encouraged to drink often. Where there were concerns about the amount people were eating or drinking specific records were kept.

Staff working with other agencies to provide consistent, effective, timely care:
- When people were admitted to hospital, staff provided written information about the person to the medical team, to help ensure the person's needs were known and understood. Care plans included prepared information sheets which provided essential information such as any special diets or how the person should be supported with mobilising.
- A social care professional told us the home worked well with them and kept them informed if there were any issues or concerns with people living at the home. A health care professional echoed these views and said the home, "Ask for advice or visits appropriately."

Adapting service, design, decoration to meet people's needs:
● The home was suitable to meet the needs of older people with reduced mobility. Adaptations had been made within the structural limitations of the building. A passenger lift was provided to enable people to access all areas of the home.
● Bedrooms were all for individual occupancy with the exception of a room shared by a married couple. People were supported to bring in items of their own furniture and personal fixtures and fittings should they wish to do so.
● There was access to an enclosed rear garden which we were told people enjoyed using in warmer weather. A small courtyard garden was also available for people should they prefer this.

Supporting people to live healthier lives, access healthcare services and support:
● People told us they received all the support they needed at the time they needed it. One relative said, "It's a small home and she gets more attention than she would in a bigger place."
● One relative told us how the manager had advocated on the person's behalf to ensure an assessment was completed to identify the correct equipment required so the person could be supported to safely sit in a chair.
● People were supported to access healthcare services when needed. Care records confirmed people were regularly seen by doctors, opticians, district nurses and chiropodists. A relative said "If they think she needs a doctor, they call the doctor." A visiting health professional told us, "They [staff] seem to manage intercurrent episodes of illness in the residents appropriately."

Ensuring consent to care and treatment in line with law and guidance:
The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Where people did not have capacity to make decisions, best interests decisions were made in consultation with family members and other relevant people. For many aspects of care best interest decisions had been made. However, this had not occurred for a person who lacked the capacity to give informed consent to their medicines although they took these willingly when staff gave these. When we discussed this with the registered manager, they undertook to ensure additional best interest assessments were recorded consistently in future.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● We checked whether the service was working within the principles of the MCA and found that they were. Staff had received Mental Capacity training.
● People and relatives told us they were always asked before care was provided. We saw within daily records that when people declined care at a given time this was respected and staff returned later to support them.
● Most people living at Victoria House had full capacity to make decisions about all aspects of their care. Staff described how they supported one person to make decisions by offering them a visual choice to support decision making.
● The manager had completed training relating to MCA and DoLS and described the action they were taking in respect of the person who had a reduced capacity to make some decisions. They were using a formal tool

to assess the person's ability to make a specific decision and were aware of the action they should take if the outcome showed the person lacked the capacity to make an informed choice.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity:
● People told us they liked living at Victoria House and were treated with consideration. One person said, "The staff are really kind, very nice to us." A relative told us staff were "Very good".
● We observed people were treated with kindness and compassion by staff. Staff spoke respectfully to people and supported them in a patient, good-humoured way. We saw a person seated in the lounge became distressed. A staff member knelt and held their hand and listened whilst the person explained why they were upset. The staff member reassured the person and stayed with them until they were more settled.
● People's protected characteristics under the Equalities Act 2010 were explored as part of their needs assessments before they moved to the home. The manager explained how they met people's individual needs.
● People's diverse needs were detailed in their care plans and people confirmed they were met in practice. This included people's needs in relation to their culture, religion, diet and gender preferences for staff support. Staff had received equality and diversity training.

Supporting people to express their views and be involved in making decisions about their care:
● Records confirmed that people were involved in meetings to discuss their views and make decisions about the care provided. One visitor told us, "Yes, I was involved [in the care plan] which was also discussed with [my relative]." The monthly newsletter for January 2019 advised people and relatives that the care plans were being reviewed and rewritten in a new format and that meetings with individual people and their relatives would be held to discuss and agree the new care plans.
● Family members were kept up to date with any changes to their relative's health needs. When asked about this, one family member told us, "Staff are approachable and we are always kept informed, for example if the doctor has been called in." Another visitor was fully aware of actions the manager was taking to ensure the correct equipment was available to support a person to safely move from their bed to a chair.
● Family members were welcomed at any time. The manager told us that families could join people for meals should they wish to do so. Important events were celebrated and relatives had been invited to celebrate Mother's Day and Christmas with their family members.
● Staff showed a good awareness of people's individual needs, preferences and interests. Care files included information about people's life histories and their preferences. Staff could use this information when talking with people.

Respecting and promoting people's privacy, dignity and independence:
● People were encouraged to do as much as they could for themselves. For example, staff described how some people completed parts of their personal care. At lunch time we saw adapted crockery such as plate

guards was available when required and staff encouraged rather than took over when people were slow to eat.

● Staff described how they supported people's privacy and dignity. This included listening to people, respecting their choices, closing doors and curtains and keeping people covered as much as possible when providing personal care. People confirmed staff always closed the curtains and ensured their dignity and privacy was maintained.

● The manager told us how they supported a person to regularly attend a community dance in another town. Support was provided in respect of transport and the person was then able to enjoy a social event with their friends without support.

● A social care professional told us how the home had supported people to become more independent with a view to them returning to their own home.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
● People told us their needs were met in a personalised way and this was confirmed by family members. This showed staff considered people individually and acted to meet their needs in a person-centred way.
● Care plans had been developed for each person. The provider and manager were re-writing all care plans to use a more person centred formalised approach. Once completed these would be discussed with the person or their family representative to agree. The new format provided a comprehensive care plan which covered all necessary risk assessments and how care should be provided to meet the person's needs. We identified some inconsistencies with care plans. The manager identified this was because these care plans had been completed by the provider and not yet fully reviewed by the home's management team to check for accuracies.
● Most care plans provided sufficient detail to enable staff to provide support in a personalised way and daily records confirmed that people received the care and support they required. We identified some areas within care plans where additional detail would be beneficial. For example, one person's care plan had a section relating to the person's mental health needs. This lacked clear guidance for care staff as to what action they should take should the person be distressed. The manager reviewed the person's 'as required' medicines administration care plan to better reflect the actions staff should take before administering medicine.
● People were cared for by a consistent staff team and care staff understood people's needs and knew how to support them according to their individual wishes and preferences.
● People were empowered to make their own decisions and choices. People told us they could choose when they got up and went to bed, where they took their meals and how they spent their day.
● People's communication needs were met. For example, staff described, and we saw, how they supported one person to make choices at meal times by showing the two options on a plate.
● People were happy with the activities provided. A person said, "I like the music when they [entertainers] come in."
● External activities providers attended the home three days each week and a range of ad hoc activities were organised by care staff. The manager had purchased a range of reminiscence topic boxes to help staff or visitors promote conversations with people.
● The manager told us that people had been able to enjoy some external trips the previous year and we saw photographs of people taken at the nearby seafront.

Improving care quality in response to complaints or concerns:
● People told us they knew how to make a complaint. Everyone said they would speak to the manager if they had a concern or complaint. One person told us, "I know the manager, I would speak with her." A relative told us that when they had raised a concern previously this had been dealt with to their satisfaction.
● The provider had a complaints policy. Information about how to complain was available for people and

relatives including in a larger print size for people with impaired vision. No formal complaints had been received since the previous inspection. The manager stated they aimed to make themselves as available as possible to people and visitors meaning any issues could be addressed promptly before people felt the need to make a complaint.

End of life care and support:

● Although no-one was receiving end of life care at the time of this inspection, the manager spoke positively about their desire to provide people with high quality care at the end of their lives, to help ensure they experienced a comfortable, dignified and pain free death.

● People's end of life wishes were discussed with them and their families and recorded in their care plans. This included information as to where people would like to be cared for and if they would wish to be admitted to hospital.

● Some staff had received specific end of life care training. The manager had links with the local hospice and was aware of how to access additional training and support should this be required.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Continuous learning and improving care:

- During the previous inspection in February 2018 we identified areas for improvement and a breach of Regulation 17 which had been repeated from the previous inspection in August 2017 as quality assurance procedures were not sufficiently robust. We told the provider they must make improvements to ensure effective systems were operated to ensure compliance with regulations and to monitor and improve the quality of the service provided. At this inspection we found improvements had been made.
- The provider and manager had introduced additional formalised audits and monitoring systems for the service. We reviewed copies of these audits, some of which had been commissioned by external specialists in the relevant area such as a fire risk assessment. The manager was also working to achieve actions required from inspections undertaken by the local authority commissioning group and environmental health in respect of food hygiene. The manager had also sought feedback from people, relatives and staff. They described how they used the findings to drive improvements in the care people received.
- The manager was aware of further areas for improvement. They had been appointed in November 2018 and told us about improvements they had identified as being required and the action they were taking to address these areas. For example, senior night staff had been appointed, new training providers were being sourced and quotes had been obtained for remedial works to the homes environment.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:

- Since the previous inspection, there had been changes in the home's management with a new manager and deputy manager appointed. There was a clear management structure in place, consisting of the provider [nominated individual], the manager and deputy manager. The provider told us they attended the home at least monthly and had regular telephone and email contact with the manager.
- People and visitors were aware of who the manager was and confirmed that they felt able to approach her should they wish to do so.
- The manager and deputy manager were clear about their roles and were supported by a head housekeeper who organised the housekeeping staff and senior care staff who lead the care staff on a day to day basis.
- Staff understood their roles and communicated well between themselves to help ensure people's needs were met. One staff member said, "We all get on well and work as a team." There was a consistent staff team and staff in various roles worked well together.
- The manager was aware of when they needed to notify CQC about incidents in the home and, with one exception, had done so when required.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility:

● People and visitors all told us the service was run well and they would recommend it to others. One person said, "I think the manager must be good as she seems to know what to do."

● The manager demonstrated an open and transparent approach and encouraged staff to do the same. They understood their responsibilities in this respect. Where people had come to harm, relevant people were informed in writing, in line with the duty of candour requirements.

● The previous performance rating and full report was displayed in the home's entrance hallway making it available to all visitors and people. This information was also included on the home's website with a link to the full report.

● Friends and family members could visit at any time. They told us they were made to feel welcome and were offered refreshment.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:

● The manager consulted people and their relatives in a range of ways. These included residents' meetings and one-to-one discussions. Records of meetings showed a range of topics were discussed with time available for people to raise any specific questions of their own.

● Where people or relatives identified areas for improvement action was taken. For example, a relative had felt that the front entrance of the home was not welcoming and appeared drab. Consequently, additional flower planters with bright flowers had been provided. The manager was looking at how they fed back action taken to people and their families. A 'you said, we did board' was now located in the entrance hall.

● Staff meetings were also held and the manager had an 'open door' approach meaning staff could raise any issues or questions at any time.

● Staff spoke positively about the manager, describing them as "approachable" and "supportive". Staff told us they felt valued and listened to by the manager.

Working in partnership with others:

● Staff had links to other resources in the community to support people's needs and preferences. This included links with local church communities and the manager described how they hoped to develop links with a nearby primary school.

● Health and social care professionals were positive about their working relationship with the manager and said they would recommend the home. The registered manager was clear about who and how they could access support from should they require this.