Supreme Care UK Ltd

Victoria House Care Home

Inspection report

71-73 Victoria Road
Polegate
East Sussex
BN26 6BX

Tel: 01323487178
Website: www.supremecareuk.com

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Victoria House on the 26 and 28 September 2018. This was an unannounced inspection.

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

Victoria House Care Home provides accommodation and personal care for up to 26 older people living with a range of health care needs. Some people required support with memory loss and dementia, whilst others were reliant on care staff to assist them with their personal care and health needs.

Victoria House Rest Home was inspected in August 2015, where it was rated overall as inadequate. A focussed inspection took place in October 2015 to follow up on concerns in relation to safety at the home and we found the provider had not made suitable improvement and the service continued to be rated as inadequate. CQC took appropriate enforcement action and the service was placed into special measures. We inspected in May 2016 to see what improvements the provider had made to ensure they had met regulatory requirements. Considerable improvements had been made and the provider was meeting all regulations. We inspected on the 20 and 25 July 2017 was to see if the improvements had been sustained. Not all improvements seen at the May 2016 inspection had been sustained and we found breaches of regulation and we took further appropriate enforcement action. In December 2017 we undertook a focussed inspection to see if the provider had made the necessary improvements. Improvements had been made and the warning notices met within the set timescale.

We undertook this unannounced comprehensive inspection to look at all aspects of the service and to check that the provider had followed their action plan and confirm that the service now met legal requirements. We found that whilst improvements had been made there were further improvements needed to ensure that improvements were consistent and sustained.

This is the second consecutive time the service has been rated Requires Improvement.

Whilst the provider had progressed quality assurance systems to review the support and care provided, there was a need to further embed and develop some areas of practice that the existing quality assurance systems had missed. This included updating care plans when an identified need or directive of care changed. For example, a deterioration in mobility and nutritional needs. People's specific personal care challenges were not always recorded clearly and responded to.

A number of audits had been developed, including those for accidents and incidents, care plans, medicines and health and safety. Maintenance records for equipment and the environment were up to date, such as fire safety equipment and,e hoists. Policies and procedures had been reviewed and updated and were available for staff to refer to as required. Staff said they were encouraged to suggest improvements to the

service. Relatives told us they could visit at any time and, they were always made to feel welcome and involved in the care provided.

People spoke positively of the home and commented they felt safe. One person said, "I feel safe, staff look after us and I see my doctor when I need to." A visitor told us, "I leave after a visit knowing Mum is safe." Our own observations and the records we looked at reflected the positive comments people made.

Most care plans reflected people's assessed level of care needs and care delivery was person specific, holistic and based on people's preferences. Risk assessments included falls, skin damage, behaviours that distress, nutritional risks including swallowing problems and risk of choking, and moving and handling. For example, pressure relieving mattresses and cushions were in place for those who were susceptible to skin damage and pressure ulcers. The care plans also highlighted health risks such as diabetes and leg ulcers. Staff and relatives felt there were enough staff working in the home and relatives said staff were available to support people when they needed assistance. The provider was actively seeking new staff, nurses and care staff, to ensure there was a sufficient number with the right skills when people moved into the home. There were systems for the management of medicines and people received their medicines in a safe way. All staff had attended safeguarding training. They demonstrated a clear understanding of abuse; they said they would talk to the management or external bodies immediately if they had any concerns. Staff had a clear understanding of making referrals to the local authority and CQC. Pre-employment checks for staff were completed, which meant only suitable staff were working in the home. People said they felt comfortable and at ease with staff and relatives felt people were safe.

Care staff were involved in developing the care plans and all staff were expected to record the care and support provided and any changes in people's needs. The registered manager said all staff were being supported to do this and additional training was given if identified as required. People were supported to eat healthy and nutritious diets. Food and fluid charts were completed when risk of poor eating and drinking had been identified and showed people were supported to eat and drink.

Staff had received essential training and there were opportunities for additional training specific to the needs of the service. This included the care of people with specific health needs such as diabetes and strokes. Staff had formal personal development plans, including two monthly supervisions and annual appraisals. Staff and the registered manager had a good understanding of the Mental Capacity Act. Where possible, they supported people to make their own decisions and sought consent before delivering care and support. Where people's care plans contained restrictions on their liberty, applications for legal authorisation had been sent to the relevant authorities as required by the legislation.

Staff had a good understanding of people's needs and treated them with respect and protected their dignity when supporting them. People we spoke with were very complimentary about the caring nature of staff. People told us care staff were kind and compassionate. Staff interactions demonstrated staff had built rapport with people and they responded to staff with smiles and good humour.

Activities were provided and were seen to be enjoyed by people who lived at Victoria House. Staff told us they were constantly reviewing activities and ensuring that they reflected people's interests. Visitors came in to play bridge once a week with their friends just as they had when they had lived at home. This was really enjoyed by people. Staff had received training in end of life care and were supported by the Local Hospice team. Visits from healthcare professionals were recorded in the care plans, with information about any changes and guidance for staff to ensure people's needs were met. The service worked well with allied health professionals.

Staff said the management team was fair and approachable, care meetings were held every morning to discuss people's changing needs and how staff would meet these. Staff meetings were held monthly and staff were able to contribute to the meetings and make suggestions. Relatives said the management was very good; the registered manager was always available and they would be happy to talk to them if they had any concerns.

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

Victoria House has improved to Good.

Measures were put in place where possible to reduce or eliminate risks. Medicines were stored and administered safely.

Comprehensive staff recruitment procedures were followed. There were enough staff to meet people's individual needs.

Staff had received training on safeguarding adults and were confident they could recognise abuse and knew how to report it.

Visitors were confident that their loved ones were safe and supported by the staff.

Is the service effective?

Good

Victoria House remained Good.
People were supported to maintain good health and were supported to access health professionals.

Staff received regular training, supervisions and an annual appraisal.

People were supported to eat and drink to maintain their health and ell-being.

People's rights were protected by staff who had received training and had knowledge of the Mental Capacity Act 2005.

Is the service caring?

Good

Victoria House remained Good.

People were supported by staff who were kind, caring and supported their independence.

People were involved in decisions about their care and the home.

People's privacy and dignity was respected and maintained.

Is the service responsive?

Requires Improvement

Victoria House remains Requires Improvement.

Not everybody had care plans and risk assessments that reflected their current individual needs.

People's preferences and choices were respected and support was planned and delivered with these in mind.

A complaints procedure was in place. People and visitors knew how to raise a concern or make a complaint but also said they had no reason to as they would speak to staff immediately.

Is the service well-led?

Requires Improvement

Victoria House was not consistently well-led.

Quality assurance systems needed to be further developed and embedded into everyday practice to ensure safe and consistent care

The registered manager, staff and provider encouraged people, their relatives and friends to be involved in developing the service.

The registered manager promoted an open culture in the service. The provider's values were embedded in staff working practices.

The service worked in partnership with other relevant organisations.

Victoria House 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 26 and 28 September 2018 and was unannounced. The inspection team consisted of two inspectors.

Before our inspection we reviewed all the information we held about the service. We looked at the providers' updated action plans following our inspection in December 2017. We also looked at the Provider Information Return (PIR) which had been submitted in July 2017. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We considered information which had been shared with us by the Local Authority and looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

During the inspection, we spoke with nine people who lived at the service, the registered manager and five staff. We looked at all areas of the building, including people's bedrooms, the kitchen, laundry, bathrooms and the lounge and dining room.

We reviewed the records of the home, which included quality assurance audits, medicine records, staff training schedules and policies and procedures. We looked at five care plans, we also looked at risk assessments, along with other relevant documentation to support our findings. We also 'pathway tracked' people living at Victoria House. This means we followed a person's life and the provision of care through the home and obtained their views. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Good

Is the service safe?

Our findings

At our inspection in December 2017 we rated this key question Requires Improvement as further time was required to ensure improvements were fully embedded into practice. This inspection found that steps had been taken by staff to ensure peoples' heath needs were managed safely and the rating had improved to Good.

People and their visitors told us they thought Victoria House was safe. One person said, "I am here for a short time before going home, I am safe but want to go home now." A visitor told us, "Really good here, I know my (relative) is in safe hands."

The provider had ensured the proper and safe use of medicines within the service. Medicine records showed that each person had an individualised medicine administration sheet (MAR), which included a photograph of the person with a list of their known allergies. MAR charts are a document to record when people received their medicines. MAR charts indicated that medicines were administered appropriately and on time. Records confirmed medicines were received, disposed of, and administered correctly. People told us they received their medicines on time. One person told us, "I trust the staff to give me my medicines, they have never let me down."

There was clear advice on how to support people to take their medicines including 'as required' (PRN) medicines, such as paracetamol. People's medicines were securely stored in the staff clinical room and they were administered by senior care staff who had received appropriate training and were competent. We observed two separate medicine administration times and saw medicines were given out safely and staff signed the medicine administration records after they had been taken. There was a clear audit trail that defined what action was taken following errors, such as medicine retraining and competency tests. When necessary, medicine errors had been reported to the local authority and the registered manager had followed the guidance for the professional duty of candour. This meant any errors or admissions were disclosed to the individual or their next of kin, an apology offered and an action plan discussed to prevent a reoccurrence. This ensured as far as possible lessons had been learnt.

Risk assessments were in place that identified specific risks to each person and provided written guidance for staff on how to minimise or prevent the risk of harm. Risk assessments for health-related needs were in place, such as skin integrity, asthma, nutrition, falls and dependency levels. Care plans demonstrated how people's health and well-being was being protected and promoted. We saw detailed plans which told staff how to meet people's individual needs. For example, people with mobility problems had had an assessment completed and a plan that gave clear guidance for staff as to what equipment should be used and how staff should support them safely. The plans gave details of specific equipment, such as type of hoist, type of sling and sling size. People assessed as at risk from falls, sensor mats had been placed in their bedrooms to alert staff the person was up and mobile. Those who had fallen from bed had had their beds lowered to reduce risk, some had a crash mat placed next to their bed to soften a fall should it occur. These strategies were reviewed regularly to ensure that they remained safe for the individual.

The home was overall clean, and there were regular audits to make sure cleanliness levels were maintained. However, there were areas that had been missed, for example a wall in the lounge area was badly marked with tea and coffee stains. From talking to both the registered manager and house keeper, it was meant to be done whilst people were in their rooms as people's chairs were in front of the wall. This was immediately addressed and would form part of a new cleaning schedule. Plans to re-decorate had been made. People told us, "Always very clean, never any odours." Staff made sure infection prevention and control was considered when supporting people with their specific care needs, such as continence care, and used the relevant personal protective equipment (PPE) such as gloves or apron when needed.

Accidents and incidents were documented and recorded. We saw that incidents were responded to by updating people's risk assessments and any serious incidents were escalated to other organisations such as safeguarding teams and CQC. Staff took appropriate action following accidents and incidents to ensure people's safety and this was clearly recorded. We saw specific details and follow up actions by staff to prevent a re-occurrence was documented. Any subsequent action was shared with all staff and analysed by the management team to look for any trends or patterns. This demonstrated that learning from incidents and accidents took place.

Staff recruitment practices remained robust and thorough. Staff were only able to commence employment upon the provider obtaining suitable recruitment checks which included; two satisfactory reference checks with previous employers and a current Disclosure and Barring Service (DBS) check.

The provider had assured that all staff had the skills, knowledge and competency to keep people safe. There was a training plan which told us staff training had been established and there was a rolling plan that ensured refresher training was booked. A member of staff told us, "We do a lot of training and complete work books." Another staff member confirmed receiving training in moving and handling and said, "The training makes sure we do things safely both for residents and us." Systems to assess staff competency to complete aspects of their roles had been introduced and were progressing to ensure all staff were competent and confident in their role. It was acknowledged that the competency templates were still being tweaked but the registered manager was pleased with the progress they had made.

There were enough staff working in the home at this time to meet people's needs. The accident and incident audits for the past six months had not identified any trends that identified insufficient staffing at any certain time. People told us the staff were always available and we saw that staff responded promptly when people used their call bell for assistance. One person said, "There is always someone around when I need help." Another person said, "I think staff are busy but they are good." Staff told us there were enough staff to provide the support people needed. One member of staff said, "It can be busy but then other times its quiet - I think we have enough staff." Feedback from people and our observations indicated that sufficient staff were deployed in the service to meet people's needs. Staff were available for people, they were not rushed and supported people in a calm manner. We saw staff sitting with people in communal areas and spending time with people. People also approached staff for support throughout the inspection process and were always engaged with promptly. Agency staff were used to cover shifts and the registered manager ensured that as much as possible they were regular staff so as to provide continuity to the people who lived at Victoria House.

Staff received training on safeguarding adults and understood clearly their individual responsibilities. Staff were able to describe different types of abuse and what action they would take if they suspected abuse had taken place. They were confident any abuse or poor care practice would be quickly identified and addressed immediately by the senior staff in the home. There were policies in place to ensure staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting

people from abuse and the contact number for the local authority to report abuse or gain any advice. We saw that safeguarding referrals had been made appropriately to the local authority safeguarding team in a timely fashion. One staff member told us, "I would raise concerns if I saw or heard anything that was inappropriate."

We discussed with staff how they made sure people were not discriminated against and were treated equally and without prejudice and their freedom respected. A senior member of staff told us, "We do have people who wish to leave but it's not safe for them to go, we treat them the same as everybody else and divert them by taking them into the garden or ask them to help us lay the tables. We ensure that this is respected by all staff." Staff were mindful of racism or sexism and respectful of people's differences. Staff had received training in equality and diversity.

Good

Is the service effective?

Our findings

At out last comprehensive inspection this key question was rated Good and this inspection found it remained Good.

People told us that staff understood them and knew how to manage their health needs. One person told us, "They know me so know when I'm not right, I can talk to them about anything." Another person said, "I think they are very good." A visitor told us, "Keep us informed and seem to be very knowledgeable." Staff told us they were required to attend all the training and were supported by management with regular supervision.

People's rights were upheld by a staff and management team who understood issues of consent and decision making. Care plans included information with regard to people's ability to make decisions about their care. Any documents to demonstrate people's decision making such as consent forms and living wills, were held on people's files. Additionally, evidence of the right of others to make decisions on people's behalf such as power of attorney for finances and /or health and welfare, was included in people's files.

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

Some people were able to tell us they felt able to make their own decisions and those decisions were respected by staff. Staff had received training and understood the principles of the MCA and gave us examples of how they would follow appropriate procedures in practice. There were also procedures to access professional assistance, should an assessment of capacity be required. Staff undertook a small mental capacity assessment for each person when they arrived at the home and this was then regularly reviewed. Staff were aware any decisions made for people who lacked capacity had to be in their best interests. There was evidence in individual files that best interest meetings had been held and enduring power of attorney consulted. During the inspection we heard staff ask people for their consent and agreement to care. For example, "Its nearly lunch time, can I help you to the table?" and "I have your tablets are you ready for them?"

We found the service had up to date policies and procedures in relation to the MCA so that staff were provided with information on how to apply the principles when providing care to people using the service and we were made aware of people subject to DoLS authorisations. The registered manager had completed appropriate assessments in partnership with the local authority and any restriction on the person's liberty was within the legal framework. We found that the service had submitted notifications to the CQC about the decisions of applications submitted for DoLS for people who lived at Victoria House.

People continued to be provided with effective care by staff who were well trained and had acquired the skills to meet people's diverse and changing needs. This included fluids and nutrition and diabetes. All staff completed a rolling programme of essential training, such as infection control, food hygiene and first aid. Regular audits were completed to ensure staff received the relevant training. The registered manager told us they were continually looking at different ways to provide and access training. The registered manager discussed introducing 'champions' in nutrition and infection control. This had been discussed with staff and it was thought this would be beneficial to consistently drive improvement and increase knowledge. The registered manager had developed a competency framework for support staff. This was to support staff to develop their skills and to build their confidence.

There was an induction for staff when they started work at the service. This included an introduction to the day-to-day routines, policies and procedures. They shadowed other staff to get to know people and the support they needed. Staff who were new to care completed the care certificate. The care certificate is a set of 15 standards that health and social care workers follow. The care certificate ensures staff who are new to working in care have appropriate introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. During this time, staff received on-going training and competency assessments. This included moving and handling, safeguarding and mental capacity.

Staff received regular supervision from the registered manager. Supervision included an opportunity to discuss training, development opportunities, and review practice. Staff told us they felt supported by the registered manager and they would be happy to discuss concerns with any senior staff.

People told us their health was monitored and when required external health care professionals were involved to make sure they remained as healthy as possible. People's health needs were supported by a local GP surgery. One person told us, "I see the doctor when I need to." Another person said, "I go to hospital appointments with staff." When required people were referred to external healthcare professionals, this included the dietician and the diabetic team. People were regularly asked about their health and services such as the chiropodist, optician and dentist were offered. Visiting healthcare professionals told us people were referred to them appropriately. One health professional said, "Things have improved, communication is better."

People's needs were assessed and care, treatment and support was delivered in line with current legislation and evidence-based guidance that achieved effective outcomes. People's skin integrity and their risk of developing pressure wounds had been assessed using a Waterlow Scoring Tool and a Malnutrition Universal Screening Tool (MUST). These assessments were used to identify which people were at risk of developing pressure wounds and action taken included appropriate equipment to relieve pressure to their skin, such as specialist cushions and air mattresses.

People's nutritional needs were met. They told us they enjoyed the food and had enough to eat and drink throughout the day. One person said, "Food is very good, plenty to eat, too much." Other comments included, "The food is nice and there's choices as well," and "There's plenty to eat, more than enough and lots of choice of drinks." Nutritional assessments were in place and identified if anyone was at risk of malnutrition, dehydration or required a specialised diet. Information about people's dietary requirements were in their support plans and in the kitchen, for the cook. Information for the cook was updated daily so they were aware of people's individual requirements. A choice of meals was offered and alternatives were available. Where necessary people's food and fluid intake was recorded. Fluid records were consistently completed.

Most people chose to eat their meals in the dining room/lounge area and the menu for the meal was

displayed on a white board along with a photograph of the meals offered. The table was laid with condiments and cutlery. People were able to sit where they wanted to and we observed people felt comfortable eating at their own pace and in their own time. This made mealtimes a sociable occasion. Meals were homemade, well presented and looked nutritious. The chef and a senior care staff member had attended training on using moulds to improve the presentation of pureed meals. Both were enthusiastic about the benefits this had had on people's appetites. People's individual preferences were taken into account when planning the menus and alternatives were always available. When people had finished their meal staff checked they had eaten enough and second helpings were offered. There was a choice of hot and cold drinks available throughout the day and fresh fruit was available in the dining room. Homemade cakes were available in the afternoons. Everyone we spoke with said they enjoyed their meals. People's weight was monitored monthly and staff sought advice as required.

People's individual needs had been met by adaptations to the home and equipment was provided to ensure they were as independent as possible. Not all rooms had an ensuite facility however there were specialised baths and wet rooms for communal use. People were supported to move around the home and were assisted to remain mobile by staff. Communal areas and most corridors were suitable for people who used wheelchairs and self-propelling wheelchairs. Walking aids, such as walking frames were provided and staff assisted people who were unable to weight bear to transfer using either stand aid hoists or electrical hoists. The lift enabled people to access all parts of the home. The garden areas were safe and accessible to people who lived at Victoria House. People had brought they own ornaments, pictures and furniture to the home if they chose to and rooms had been personalised pieces of furniture and photos of relatives and pets.

Good

Is the service caring?

Our findings

At out last inspection this key question was rated Good and this inspection found it remained Good.

People were supported by staff that were kind and caring. One person told us, "Very kind and caring, all of them." People told us they were treated with respect and their dignity maintained. One person said, "Staff know and understand me and definitely my privacy and dignity is very much respected."

People were supported by staff who knew them well and had a good understanding of their needs. They knew what was important to people as well as their support and care needs. Relationships between people and staff were positive and caring. Staff had a caring approach and were patient and kind. They had time for people, their interactions were warm and friendly and, they looked approachable. Throughout the inspection, we observed staff checking with people to ensure they were okay or if they needed any support. Staff also sat with people chatting, assisting them with music choices and engaging in one to one activities such as jigsaw puzzles.

People were treated with respect and dignity. The home had a relaxed atmosphere. People responded positively when staff approached them in a kind and respectful way. People nodded and smiled when asked if staff were kind and caring. Relatives felt staff offered the care and support people needed and wanted. One relative thought the staff were, "Really kind and patient" and, "Nice atmosphere, welcoming and friendly." We saw throughout the inspection people made their way to the office to see the registered manager for a chat. One person said, "I can go and talk to (the registered manager) and have never been turned away."

People were treated with kindness and respect and as individuals. It was clear from our observations that staff knew people well. Staff made eye to eye contact as they spoke quietly with people; they used their preferred names and took time to listen to them. Staff knocked on people's bedroom doors before they entered, saying, "Good morning (name) would you like me to help you?" and, "Shall I take you to the lounge?"

People's privacy and dignity was protected when staff helped them with personal care and bedroom doors remained closed as people were assisted to wash and get up. When staff assisted people to move in communal areas they ensured their modesty was protected and they were moved respectfully. Staff told them what was happening and explained what they were doing. Staff told us, "People need a lot of support with their personal care and we keep in mind at all times that some things are very private." This showed staff understood the importance of privacy and dignity when providing support and care.

People's equality and diversity needs were respected and staff were aware of what was important to people. People were encouraged to be themselves. One person said, "I know that I can be myself and staff accept me." Another person told us, "I like to wear my cap as I like to look smart, staff help me."

The ethos of Victoria House Care is to retain the quality of life and maintain the independence of people and

to support them as needed with their individual needs, wants and wishes. Staff told us they supported people where needed to minimise risks without restricting what they would like to do. This was managed by listening to what people would like to do and what they hoped to achieve. We saw that staff encouraged people to make everyday choices and to be as independent as possible. This was supported by the care plans and risk assessments we saw.

Staff promoted people's independence and encouraged them to make choices. We saw that those people who liked to move around independently were supported discretely by staff. Staff talked to people and asked them if they needed assistance, they explained to people what they were going to do before they provided support and waited patiently while people responded. One staff member said, "It's time for lunch, are you hungry?" They leant down to talk to the person face to face so they could see their expression, and waited until the person responded. Comments from staff included, "We encourage people to be independent as they can be. We give them space and respect their independence" and, "We let people to make their own decisions if they can. For example, if someone doesn't want to do something then we make sure we offer later." Some people were able to confirm that staff involved them in making decisions on a daily basis. One person said, "I can choose to have lunch in my room or in the dining area. Staff always ask me." Another person said, "Due to my health I spend a lot of time in bed, but staff encourage and support me all the time but never nag me."

People's preferences were recorded in the care plans and staff had a good understanding of these. There was information about each person's life, with details of people who were important to them, how they spent their time before moving into the home, such as looking after their family or employment, hobbies and interests. Staff said they had read the care plans and told us each person was different; they had their own personality and made their own choices, some liked music and noise while others liked to sit quietly, and they enabled people to do this as much as possible. People chose how and where they spent their time. People, who wanted to sit and watch television or do a jigsaw, rather than participate in activities, were supported to do so.

People's rights to a family life were respected. Visitors were made welcome at any time and were able to have meals with their loved ones. Lounge areas were welcoming and we saw people enjoying spending time in this area with visitors during the days of our visits. Newspapers and books were available. There were items of interest displayed on boards, such as photographs of staff, regular visitors, newsletters, details of events that had taken place, the weekly activities programme, health information booklets and advice about advocate services. Information on the use of advocacy services was available and the registered manager confirmed the home worked in partnership with Independent Mental Capacity Advocates (IMCA) when required. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights. One relative told us, "We are always welcomed and feel at home, tea, coffee and cake is always offered." Another relative said, "Always made to feel welcome, staff make time to talk to us and answer any questions we may have."

People and families were able to express their views and were involved in making decisions about their care and support and the running of the home. Resident and family meetings had been held on a regular basis. These provided people with the forum to discuss any concerns, queries or make any suggestions. We saw that ideas and suggestions were taken forward and acted on. For example, menus, activities, trips out and laundry services.

Care records were stored securely in the staff offices. Information was kept confidentially and there were policies and procedures to protect people's confidentiality. Staff had a good understanding of privacy and

confidentiality and had received training.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection, this key question was judged to be Requires Improvement. This inspection found that it remained Requires Improvement.

People and their relatives were involved in developing their care, support and treatment plans as much as it was possible. Some people said they were aware of their care plan and that their care needs had been discussed with them. One person said, "I'm involved in all my care." Another person said, "Staff sit and go through my health and discuss any changes with me." They also said, "I came here from hospital and could not care for myself, it was all arranged for me and I was involved every step of the way."

Care plans contained a good level of information that guided staff to deliver the care the person needed and in a way the person wanted. Three people felt the care provided was individual and focused on their needs, other people were unable to tell us but the documentation evidenced input from family members. Care records were detailed and evidenced that staff knew people well. However, we found care plans had not always been updated to reflect significant changes to people's health and well-being. For example, one person's care plan stated they could mobilise independently but following a stroke their mobility needs had changed. Another person remained on continuous bedrest and there was little documented as to the reasons why they were in bed and how they needed to be positioned when they received food. Some people had become non-compliant with specific aspects of personal care, and this had not been reflected within their care documentation. There was no record of what staff had tried to resolve the issue and no evaluation to decide on the next steps. Staff we spoke with were aware of the changes and were able to discuss them in detail. As agency staff were used and new staff had been employed there was a risk that staff would not be responsive to people's individual needs and people would not receive consistent safe care. The care plans were updated immediately during the inspection process. This was an area that required improvement.

Other care plans reviewed had captured people's individual needs, the outcomes the support and care aimed to achieve and the action staff had taken to achieve this. For example, one person was at risk from skin damage. The care plan identified the risk by using an assessment tool and gave clear instructions regarding preventative measures, such as airflow mattress and two hourly re-positioning. Another person's need was assistance with mobility. The outcome was for staff to ensure their walking aids were always near them and that staff accompany them to ensure they were safe. Staff followed these care directives and this person was seen walking with their walking aid around the home, supported by staff. For another person who had become increasingly frail and at risk from falling out of bed, staff had lowered the bed and placed a crash mat with a sensor mat by their bed to alert staff. Staff reviewed these strategies regularly to ensure they remained appropriate. Staff demonstrated a good understanding of this person's changing needs, both health and socially. One member of staff said, "If someone becomes confused or appears unwell we look for a cause, such as a urine infection and immediately encourage fluids and contact the doctor." Another staff member told us that they monitored people's weight and immediately sought advice if a person was losing weight.

There was no activity coordinator in post. Activities were provided by the care staff and a member of the

evening kitchen team came in earlier to provide one to one time with people. The staff we saw providing activities did so with enthusiasm but as we discussed training in providing meaningful activities would be beneficial to take activities forward and be more person centred. Since the last inspection staff had introduced an activity cupboard that they added to when ideas were shared. The cupboard had arts and craft materials, board games, jigsaws and books. The staff had introduced a wish tree, where people wrote their wishes and a tree which shared people's interests and past accomplishments. Such as past trips abroad and jobs; this helped staff and people to have an understanding of each person and facilitate planned events. Activities were offered during the inspection process and people enjoyed them. The more mobile and able people enjoyed laying the tables for lunch and helping staff with some jobs.

External entertainers came to the home and included exercise sessions and pet therapy. We talked to people who enjoyed family visits and other people were happy to pursue friendships and their own pastimes such as reading. People told us, "I do my own thing but will come to some special events," and "I prefer to stay in my room most of the time, I enjoy the dog visits." Most people were able to express their views on the lifestyle at Victoria House and were happy there. One person said, "It's homely, staff are really nice." Another said, "I enjoy life here, it's comfortable and I'm safe." The registered manager told us that activities were an area that they had identified as needing to be developed. Staff were enabling people to undertake small house hold tasks which made them feel valued. One person said, "I like to keep busy." The provider was improving the communal areas to provide a lounge area for families to have private times and people were involved in choosing colour schemes in the lounge.

The home encouraged people to maintain relationships with their friends and families. One person said, "My friends and relatives visit regularly and are always welcomed." Another said, "I feel the home is welcoming, my family visit regularly, staff always pop in and chat to them and offer them a drink." We saw visitors were welcomed throughout our inspection and the interactions were warm and friendly. Visitors were complimentary about the home, "Very welcoming, and friendly," and "Lovely home, clean and comfortable."

The staff team had a good understanding of the Accessible Information Standard and discussed ways that they provided information to people. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Pictorial aids were used throughout the building to help people with finding their way to the communal areas, menus, activity programme and date boards were displayed both in written and pictorial format. For those who had a visual impairment staff used large print and said they could provide information on tape so people listen to the information.

The registered manager and staff worked with other healthcare professionals to ensure people could remain at the home at the end of their life and receive appropriate care and treatment. This included having 'anticipatory medicines' available, so people remained comfortable and pain free. End of life care plans were in place for people, which meant staff had the information they needed to ensure people's final wishes were respected. Where people had chosen not to engage in these conversations, with the person's permission, discussions had been held with family and those closest to them. We looked at the care plan for one person who had recently received end of life care. The documentation had reflected that care had been adjusted for this stage of their life. It emphasised the need for constant monitoring of pain and of ensuring that food and fluids should be offered regularly in small amounts.

The provider had established an accessible effective system for identifying, receiving, recording, handling and responding to complaints. A complaints procedure was in place and displayed in the reception area of the home and in other communal areas. The complaint system was also available on the website for the

service. People told us they felt confident in raising any concerns or making a complaint. One person told us, "Yes I know how to moan and make a complaint." Another said, "I would tell one of the staff and I know it would be taken seriously." Complaints were recorded and responded to as per the organisational policy. A complaints log was kept and monitored by the registered manager. There was evidence that complaints were fully investigated, responded to, apologies given if there was a need to with actions they were going to take.

When compliments and thank you cards had been received these were shared with staff at meetings and showed staff they were appreciated.

Satisfaction surveys had been sent out regularly in respect of getting feedback on the service. These were collated and the survey outcomes shared with people families and staff. The actions to be taken were also shared. One visitor said, "I have been asked to complete forms about the service - I give feedback all the time."

Requires Improvement

Is the service well-led?

Our findings

At the last inspection, this key question was judged to be Requires Improvement as time was needed to embed robust quality assurance to drive and sustain improvement. This inspection found that it remained Requires Improvement. We found improvements in some areas but they had not been consistent and the systems in place to assess the quality of the service provided or to monitor and mitigate risks to people were not fully implemented or embedded into practice.

People spoke well of the service. One person said, "I'm happy here." Another person told us, "They are kind and I can talk to them about anything." Other comments included, "Nice place to live, we do have a laugh." Staff told us they felt well supported by the registered manager and the management team. They said they were quite able to approach the registered manager or a senior for advice." Visitors told us, "Its improved, better communication, work is being done on the décor, and I know Mum has been consulted about colours." Another visitor said, "I think it's actually good here, it's not perfect, but it's safe, warm, staff are kind and the food is good."

A governance framework was in place and the registered manager and provider had access to a range of tools to help them monitor, review and assess the quality of the service. These included satisfaction surveys; annual management reviews, care plan audits, medication audits, maintenance programme and provider visits. The quality and depth of the audits had improved but needed to be more robust to ensure that shortfalls. For example, care plan reviews had not always been clear. We acknowledge that there was an issue with the computer care plan evaluation setting and this had prevented staff from being able to update a care plan without rewriting the entire care plan. However, the system at present for reviewing was not robust, we found evidence to support this within three care plans and risk assessments that were not up to date and accurate. Further audits for checking the cleanliness of the service needed to be developed to ensure that the environment remained clean and safe for people, this pertains to the walls in the communal areas.

Our observations of care delivery on the second day of the inspection identified that more senior oversight was needed on the floor. We saw that some staff who were new to care had not fully understood when people needed assistance with eating and drinking. We received feedback from health professionals that they felt staff needed further support and training in recognising when a person was becoming unwell or had a additional health issue. These were areas that required improvement to ensure that improvements were embedded and sustained to ensure people received consistent safe care.

People, staff and visitors were regularly asked for their feedback about the service. This happened informally throughout each day when staff spoke with people whilst supporting them. People were also involved in meetings with families, where they were able to discuss their experiences at the service and highlight areas which could be improved. Staff attended regular staff meetings to discuss the service, people and training needs. Feedback from staff had identified to the registered manager that staff would like more interactive training. Actions to rectify this were taken by the management team. Staff were signed up for training with East Sussex County Council. The provider had arranged for staff to attend train the trainer courses in

medicine management. The registered manager had had training to be medicine assessors and this had ensured safe medicine practices and competencies. The registered manager also discussed the development of staff which included staff becoming champions in specific areas of interest.

We asked the registered manager to tell us what they were proud of. She told us, "We have come a long way, we know we need to still recruit staff who have experience and we have one starting soon who after a full induction will hopefully become a senior." There was a positive, open and person centred culture at the service, all staff were transparently honest and talked of the challenges they had faced and were facing. The registered manager was visible and worked at the service five days a week. She had a good understanding of people and their individual support needs. There was evidence of close working between the registered manager and provider to improve and develop the service. The registered manager told us that they had an open door policy, which has really supported the home to be able to rectify any concerns before they become bigger issues and offer support in any areas where it may be needed. This was evidenced throughout the day when visitors, people and staff visited the registered manager for advice, updates and informing her of any concerns. It was a difficult week for staff due to deaths, but the staff coped well with good support from the registered manager.

The registered manager believed that this had allowed peoples' voice to be heard and that people knew their opinion really mattered to the service and that, "We listen to what they had said and act on their suggestions. We involve them in any changes to the home and always introduce new staff to each person." Staff told us they enjoyed working at the service. They said there was good teamwork and the management team and their colleagues were supportive. One staff member said, "It's not easy when staff are new because it takes time to learn about people because even though they have an induction, people here are all very different." There was evidence of good communication at the daily meetings where staff demonstrated a good understanding of people's needs and their roles and responsibilities. There was on-going communication across the team and staff were regularly updated about people's needs at handover and staff meetings. Staff were involved in the development of the service. The registered manager told us they had worked with staff to develop the ethos and values for Victoria House. 'The ethos of Victoria House Care was to retain the quality of life and maintain the independence of the service users and to support them as needed with their individual needs, wants and wishes.' Staff discussed the values as being open, kind, respectful, and to engage and involve people in the improvements and development of the service.

There was evidence that the service worked effectively with other health and social care organisations to achieve better outcomes for people and improve quality and safety. The health and social care professionals we contacted during the inspection process did not express any concerns at the time of our inspection. External health care professionals such as the GP and dietician contacted informed us that staff were kind and followed their guidance. The negative comments we received from health professionals were balanced by the comment, "There have been improvements recently and lessons have been learnt and put in to practice."

Falls, accidents and incidents were recorded, monitored and an action plan put in place to prevent a re-occurrence. Call bell responses were monitored to ensure staffing levels were sufficient. On discussion with the registered manager, future actions of persistent falls may include looking at a more suitable room location for certain people. This would only happen if it is in the best interest of the person. Medicine audits looked at record keeping and administration of medicines and the manager said action would be taken through the supervision process if issues were identified.

From April 2015 it was a legal requirement for providers to display their CQC rating. The provider was displaying their rating correctly. The provider had notified CQC of significant events which had occurred in

line with their legal obligations. The registered manager was aware of their responsibilities under Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to, it requires providers to be open and transparent and sets out specific guidelines providers must follow if things go wrong. Staff told us they were open about all aspects of the support provided and they contacted relatives or their representatives, with people's permission, to inform them of any concerns they might have. For example, if a person's health needs had changed and their GP had been contacted.

The registered manager had an understanding of General Data Protection Regulation (GDPR) which came into effect in May 2018. GDPR was designed to ensure privacy laws were in place to protect and change the way organisations approach data privacy. Staff said they were currently reviewing their record keeping and had sought advice on how to best make the changes required under this legislation. We saw that people's personal information was protected.