Care Quality Commission

Valant Care Limited

Victoria Royal Beach

Inspection report

12-16 Grand Avenue, Worthing,
West Sussex BN11 5AW
Tel: 01903 246499
Website: www.victoriaroyalbeach.co.uk

Date of inspection visit: 19 October 2015
Date of publication: 23/11/2015

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

Overall summary

The inspection took place on 19 October 2015 and was unannounced.

Victoria Royal Beach is a privately owned care home in Worthing and is registered to provide care for up to 20 people. At the time of our inspection, there were 16 people living at the home and all rooms were single occupancy. Victoria Royal Beach has been converted into a home from three properties that were originally terraced. It is situated within a few minutes of the seafront at Worthing and close to the town centre. The majority of rooms have en-suite facilities and those facing on to Grand Avenue, at first floor level, have a balcony. Communal areas comprise a large sitting room, dining area within a conservatory and a quiet lounge, where people can meet with relatives and friends. The home has accessible gardens to the front and side and there is a five person lift within the property.

The person currently managing the home had not yet registered with the Commission as they had only been in post for three months and were in the process of completing their probation period with the provider. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

People's medicines were not always managed so that they received them safely. Some Medication Administration Record (MAR) charts had not been completed correctly, which meant that some people may not have received their medicines as prescribed. Two medicines had been over-ordered and stocks of these medicines were excessive. A refrigerator to store some medicines was not locked. MAR charts, containing people's information, were left out on a shelf in a room with the door open and were not kept confidentially. No formal system was in place to audit medicines to ensure this was managed safely.

There were no formal processes or systems in place to audit the quality of care delivered. Risks were not always assessed and monitored overall to ensure people's safety. No formal meetings were arranged that enabled people or their relatives to feed back their views about the service.

People were protected from abuse and harm. Staff were trained to recognise the signs of potential abuse and knew what action to take. Individual risks to people had been identified and assessed and care plans provided information and guidance to staff on how these should be managed. When accidents or incidents occurred, these had been reported in line with legislation. However, the reports did not identify steps that could be taken to prevent a reoccurrence. Staffing levels were sufficient to meet people's needs safely and the provider followed safe recruitment practices.

People were looked after by staff who had received training in all essential areas. New staff were required to complete the Care Certificate, a universally recognised qualification. Staff had regular supervision meetings, but no arrangements were in place for formal staff meetings. However, staff communicated information about people's care needs at daily handover meetings between shifts. Staff had a good understanding of the need to gain people's consent before delivering care. People's capacity to make decisions had been assessed in line with the requirements of the Mental Capacity Act 2005 (MCA). People did not have their freedom restricted and no applications had been made to the local authority under the provisions outlined in the Deprivation of Liberty Safeguards (DoLS).

People were supported to have sufficient to eat and drink and to maintain a healthy lifestyle. A variety of meals were on offer and people could choose from several options on the menu. Special diets were catered for and people's nutrition was assessed and their weight was recorded and monitored. People had access to a range of healthcare professionals as needed.

People were looked after by kind and caring staff who knew them well and they were encouraged to be as independent as possible. People were treated with dignity and respect. When they reached the end of their lives, they were supported to have a comfortable, dignified and pain-free death in line with what they requested.

Care plans provided detailed, comprehensive information to staff about people and all aspects of their care needs. The majority of care plans included details about people's life histories, but not all plans were completed consistently and had the same level of detail. There was a range of organised activities at the home, but there was no evidence to show that people had been involved in planning these activities. People could go out with relatives and friends, but there was a lack of staff to support people in the community, unless it was for healthcare appointments.

There was a complaints procedure and policy in place, but no formal complaints had been raised or recorded within the year.

People were not formally asked for their views about the service, although the manager did meet with people every day to obtain their feedback. The manager was fairly new in post and was concentrating on building a fully trained and skilled staff team.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
Not all aspects of the service were safe.

People's medicines were not always managed so that they received them safely. There were inaccuracies in the Medication Administration Records (MAR) and some medicines were not stored safely.

People were protected against the risk of abuse and harm and staff had been trained to recognise this and knew what action to take.

There were sufficient numbers of staff on duty to care for people safely and safe recruitment practices were followed.

Requires improvement

Is the service effective?
The service was effective.

People were cared for by trained staff and were involved in decisions about their care.

Staff knew how to gain people's consent in line with current legislation. People were not deprived of their liberty.

People had sufficient to eat, drink and maintain a healthy lifestyle. They received support from healthcare professionals as needed.

Good

Is the service caring?
The service was caring.

People and staff knew each other well and warm, caring relationships had developed. People and their relatives were involved in planning and reviewing their care.

When people reached the end of their lives, they were supported to have a comfortable, pain-free death and were involved in decisions relating to this.

Good

Is the service responsive?
The service was responsive.

Care plans provided comprehensive information to staff about people, their needs and how they wished to be cared for. Care plans were reviewed monthly.

A range of organised activities was available to people on a daily basis.

Complaints were addressed and managed appropriately in line with the provider's policy. Most complaints were dealt with promptly on an informal basis.

Good

Is the service well-led?
Some aspects of the service were not well led.

Requires improvement

Summary of findings

There were no formal systems or processes in place to measure the quality of care delivered or to ensure that risks were managed appropriately.

The manager had not yet registered with the Care Quality Commission.

People and their relatives felt the manager and staff were very approachable and that their views were sought on an informal basis.

Victoria Royal Beach

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.

The inspection took place on 19 October 2015 and was unannounced. Two inspectors undertook this inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people and staff. We spent time looking at records including six care records, four staff files, medication administration record (MAR) charts, staff rotas, staff supervisions, the staff training plan, complaints and other records relating to the management of the service.

On the day of our inspection, we met with four people living at the service and two relatives. Due to the nature of some people's complex needs, being asked questions by an inspector would have proved too distressing. We did, however, chat with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the provider, manager, two care staff and the chef.

The service was last inspected in November 2013 and there were no concerns.

Requires improvement

Is the service safe?

Our findings

People's medicines were not always managed so that they received them safely. We checked all the medication administration records (MAR) and found some inaccuracies. For one person, the MAR showed two instances, on 15 October and 17 October, where staff, instead of initialling to confirm the person had received their medicine, had written 'X'. It was not clear whether the person had received their medicine as prescribed or whether, for example, they had refused it. On 18 October, staff had failed to sign this person's MAR to show whether another medicine had been administered or not. We brought this to the manager's attention and they said they would follow this up with the staff on duty on these dates.

Drugs that were required to be refrigerated to ensure their efficacy were stored in a refrigerator dedicated to the storage of medicines. This had a lock to enable it to be secured, but the key had been left in the lock. The manager said that only insulin and eye-drops were kept in the refrigerator and that they felt this did not pose a risk. However, anyone could have helped themselves to, or tampered with, the medicines kept in the refrigerator as the door to the medicines room was left open. In addition, the MAR sheets were kept on an open shelf, so that people's personal information was not kept confidential. Stocks of medicines were stored in a locked cupboard. There were excessive stocks of two medicines, paracetamol and warfarin. The manager was aware of this and said that medicines had been over-ordered by the previous manager for two people and that these medicines were gradually being used up.

Controlled drugs were managed safely. Controlled drugs are drugs which are liable to abuse and misuse and are controlled by the Misuse of Drugs Act 1971 and misuse of drugs regulations.

Records relating to the stock levels and administration of controlled drugs were in order. However, one medicine buscopan, which can be obtained over the counter, had been locked in the controlled drugs cupboard. This medicine had not been checked in by staff and should not have been stored in the controlled drugs cupboard. The manager told us that they undertook regular medicines audits to ensure that there were sufficient supplies of medicines in stock. This audit also included the checking of MAR charts. However, the manager said that these checks were not recorded within any formal audit and no records could be produced to confirm that the audits had taken place.

The above evidence shows that medicines were not managed safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to take their medicines safely. Medicines were administered from two medicines trolleys, one located on the first floor and the other on the ground floor. On the day of our inspection, we observed staff administering medicines appropriately, the MAR chart was checked for the correct dosage and signed by staff. In between administering each medicine, the medicines trolley was locked. The service had a protocol in place with guidance for staff on PRN (as required) medicines. There was a policy in place for homely remedies which identified particular over the counter medicines, indication for use, dosage, maximum daily dose and any special precautions to be taken account of in relation to people's prescribed medicines. Staff were trained in the administration of medicines and were observed by more experienced staff to assess their competency.

We observed staff wore personal protective equipment when they were delivering personal care to people. Overall, the home was clean and hygienic. However, we saw that an old dining chair had been placed in an upstairs bathroom. This dining chair was constructed mainly of wood, with a plastic seat and was used by people before or after they had a bath or shower. The chair was not suitable for use in a bathroom and the wood could not be cleaned easily to render it hygienic. We brought this to the manager's attention and they stated that the chair would be removed.

People were protected from abuse and harm. People told us they felt safe living at the home. One person said, "Yes, I do feel safe. I can't say I really think about it". Another person told us, The staff are wonderful and caring. I do feel safe, yes". A third person said, "I used to fall quite a lot at home, but I haven't fallen since I've been here". Relatives had no concerns about the safety of family members. One relative said, "We'd move our relative straight out if we suspected abuse was going on here, but it doesn't".

Two incidents had been reported to CQC by the manager within the last year and appropriate action had been taken,

Requires improvement

Is the service safe?

resulting in staff being investigated by the relevant authorities and leaving the service. Staff had received training in safeguarding adults at risk and knew how to recognise the signs of potential abuse. One member of staff named the types of potential abuse and said, "There's lots, like physical, mental and emotional abuse". Staff said they would report any concerns to the manager. Another staff member said, "Report it to the manager straight away. I'd let the senior on shift know, so they're aware". The home had a copy of the latest West Sussex safeguarding policy, as well as the provider's safeguarding policy, which was available for staff to access.

Risks to people and the service were managed appropriately. We asked people about their rights to make choices for themselves. One person told us, "The staff are very good. I can do more for myself than most and they just let me get on with it". Another person said, "I can do some things for myself and it varies from day to day, but the staff always ask before helping". A relative told us, "I like the way staff will always give people the chance to do things for themselves. It must be a risk for them, but they do it anyway". Another relative said, "I was keen when I chose this home that staff would treat my relative like an adult and they do".

People's risks had been identified and assessed in a range of areas. For example, one person's risks had been assessed in their mental health, physical health, behaviour, falls and skin integrity. A risk assessment in moving and handling had considered the person's physical and mental condition, activity and their comprehension of the risk. The risk had then been assessed as medium and included any special assistance that might be required by the person and guidance for staff. Risk assessments were reviewed monthly and care plans updated as needed. Risks to people were also discussed on a daily basis by staff at handover meetings between shifts.

The provider recorded all incidents and accidents appropriately. Each incident or accident contained a clear description and whether it should be reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR). These regulations state that employers and those in control of premises are required by law to report specified incidents and accidents. Each accident or incident form explained the outcome of the incident. However, they did not contain details of how a re-occurrence could be avoided. No audits had been completed to inform the provider of any trends or triggers indicating a particular hazard or area for improvement.

There were sufficient numbers of suitable staff to keep people safe and meet their needs. We asked people and their relatives the question, "Do you think there are enough staff on duty to consistently care for people safely?" One person told us, "Yes, I think so. I have no complaints and there seem to be staff around all the time". Another person said, "I don't feel rushed particularly, but they're very busy. I think some staff have left". A third person told us, "The staff are very caring. I feel I have plenty of time, but then I don't need as much care as some others". A relative said, "I think there are enough staff. The call bells are answered pretty quickly I think". Another relative said, "I've never noticed a problem. However, another relative told us, "The staff are all kind and considerate. I think sometimes they are short staffed, but it's like that everywhere I suppose". A member of staff felt that staffing levels were adequate and said, "It can be very busy, but not every day's like that. Overall, it's not too bad". Whilst additional staff were organised to take and support people to their healthcare appointments, there were insufficient staff available to take people out into the community. People relied on their relatives or friends if they needed support to go out.

The manager said that they were in the process of recruiting three new staff to cover existing vacancies. Where necessary, they had used agency staff to fill any rota gaps; the same agency staff were used to ensure consistency of care. Staffing rotas confirmed that there were sufficient staff on duty to meet people's needs safely at all times and our observations at inspection confirmed this.

Safe recruitment practices were followed. Records confirmed that, before new staff were allowed to commence employment, two references had been obtained, their employment history checked and their identity verified. Checks were also made through the Disclosure and Barring Service (DBS) to ensure new staff were safe to work in the care profession.

Good

Is the service effective?

Our findings

People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. People and their relatives confirmed they were happy that staff had sufficient skills and experience to care for people safely. One person referred to staff and said, "They are marvellous and so caring". Another person told us, "I do have a lot of faith in them. When I was ill they called the doctor straight away". A relative said, "I think with the new manager, things have gone up a gear. Not that it wasn't good before, but the new staff seem really good".

Several staff had left recently and the new manager was in the process of ensuring that new staff completed all necessary training. New staff were required to complete the Care Certificate, covering 15 standards of health and social care topics, which is a national qualification. Existing staff had completed qualifications in health and social care, such as National Vocational Qualification (NVQ) at level 2 or 3. New staff completed their induction by reading care records, meeting people and looking through the provider's policies and procedures. They work shadowed experienced staff. One member of staff described this and said, "I work shadowed for a week, then I had a week on my own when I took the lead and a senior shadowed me".

Essential training for staff was in the form of on-line training and covered health and safety, infection control, safeguarding, food hygiene, capacity, medicines and dementia awareness. Face to face training was organised in moving and handling, first aid and fire safety. One new member of staff had not yet started any on-line training, but demonstrated their competency through training from a previous employer, with certificates to confirm this.

The new manager told us that they were in the process of organising monthly staff meetings. In the interim, daily handover meetings afforded staff the opportunity to feed back to the manager any concerns or issues they had relating to people's care. All staff had attended recent supervision meetings with the manager and records confirmed this; new staff received additional support from the manager throughout their probation period.

We asked people and their relatives about issues of consent and whether they were involved in decisions concerning people's mental capacity. One person said, "I do get a bit confused from time to time, but they [staff] don't rush me. I can still make decisions most of the time and they let me". A relative told us, "The manager's door is always open. It's something we've spoken to them about before as my relative is getting more and more confused. The manager explained that they'd keep an eye on it and keep in touch about it".

Care plans confirmed that written consent had been sought from people in a variety of areas. These included photography for identification purposes and consent for outside agencies to examine care plans. Care plans contained mental capacity assessments where necessary and up-to-date and relevant risk assessments were in place as a result of these. Training was delivered to staff so that they understood the requirements of the Mental Capacity Act 2005 (MCA) and associated legislation under Deprivation of Liberty Safeguards. Some new staff appeared doubtful as to the exact purpose of the MCA, but had a good understanding of people's capacity to make everyday decisions. One person had a particular health condition which meant that their movements needed to be monitored to ensure their safety. A best interest decision had been taken and sensor mats put in place. A best interest decision is where people's relatives, care professionals and staff get together to make a decision on behalf of the person. No-one had their freedom restricted unnecessarily at the home and the manager had not applied for DoLS to be authorised by the local authority. DoLS protects the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm.

People were supported to have sufficient to eat, drink and maintain a balanced diet. One person said, "The food is good, yes". Another person told us, "It's gotten much better lately. There seems to be more choice". A third person said, "I like the food. There's quite a lot of variety". A relative said, "The food is yummy" and another relative commented, "My mum had lost quite a lot of weight before coming in here. She's put it all back on now and more besides. I'm not surprised. The food is very good". The food was served promptly at lunchtime, with enough staff present to ensure those who required assistance received it. People were asked what they would like to eat for lunch by the manager during the course of the morning and desserts were chosen by people after they had finished their first course. This

helped people with short-term memory loss to receive the choice of food they wanted at the point of delivery, as they may have forgotten food choices they had made previously.

The dining room was an open area with views to the garden. Tables were laid up with tablecloths, napkins and condiments. There was a small lamp on each table and the way the room was set up looked inviting. People were offered the choice of an alcoholic beverage before lunch. On the day we inspected, people had the choice of lamb casserole or smoked haddock with a selection of fresh vegetables. There were four dessert choices on offer to follow. Home-made cakes were available to people during the afternoon.

We asked kitchen staff how they managed people's dietary needs and how likes and dislikes or changes in people's special diets were communicated. Kitchen staff kept a list of people's likes and dislikes, which was regularly updated. Staff had a good knowledge of people's dietary requirements, including those requiring special diets. Communication between kitchen and care staff was good. Care staff advised the chef of changes made to people's diets following input and advice from visiting professionals, such as speech and language therapists.

People at risk of poor nutrition were regularly assessed and monitored using the Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify people who are malnourished, at risk of malnutrition or over weight. All people with special dietary needs were regularly assessed by external professionals, including the GP and dietician. People's weights were recorded at least monthly and food and fluid charts were in place to monitor how much people had eaten and drank on a daily basis. A member of staff explained how they encouraged people to have a regular fluid intake. They said, "I give them water and tell them the doctor wants them to drink it". This was particularly successful for people who had been suffering from urinary tract infection. One person had lost six kilogrammes of weight in a short space of time. The provider had identified this quickly through the use of MUST and involved external health professionals in further assessment and treatment. As a result, the person regained the lost weight.

People were supported to maintain good health and had access to healthcare services and support. We asked people and their relatives about their experiences of the health care they received. One person said, "If I need a doctor, they will get one straight away". A relative told us, "I know the district nurse comes every day at the moment. The staff here seem very good at calling in help if they need it". We observed the manager contacting the local surgery to request a GP visit on the day of our inspection. Care records confirmed that people received support from a range of professionals including their GP, dentist, chiropodist, optician and audiologist. In addition, a hairdresser visited weekly.

The provider said that they had plans in place to update and refurbish certain parts of the home, to make these more accessible and comfortable for people. For example, a ground floor bathroom, not currently in use, would be converted to a wet room. Overall, the home was warm, comfortably furnished and had a homely feel. For example, in the hall area, there was a grandmother clock, vase of flowers, pictures on the wall and seats available for people. A lounge was available, separate to the main sitting room, so that people could meet with their relatives in private.

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. We observed that one person had finished their favourite brand of squash. The manager immediately offered to arrange to buy them two more bottles, so that they would not be without. We asked people and their relatives about the caring approach of staff. One person said, "Well, they are very caring, all of them. I think they're wonderful. I'm not a bit sorry I left my home to come here". Another person told us, "Well, I don't need much care and I keep myself to myself, but I can see they [staff] are very caring". A relative commented, "I'm thrilled with it really. The staff are so caring and the manager is very approachable".

We observed care at lunchtime and in communal areas throughout the day. The care was safe and appropriate, with adequate numbers of staff present. We observed excellent interaction between people and staff who consistently took care to ask permission before intervening or assisting people. There was a high level of engagement between people and staff. Consequently people, where possible, felt empowered to express their needs and receive appropriate care. For example, at lunchtime the dining area was particularly warm. Staff members approached each person to ask if they were comfortable and moved one person, at their request, to another part of the home to eat lunch.

People who were unable to express their needs received the right level of support, for example, in managing their food and drink. It was evident throughout our observations that staff had enough skill, empathy and experience to manage situations as they arose. Care given was of a consistently high standard. A member of staff said, "I love my job. The residents are great. They make your day sometimes".

People were supported to express their views and were involved in making decisions about their care, treatment and support. We asked people and their relatives whether they had been involved in making decisions about their care and treatment. One person said, "Oh yes, not that I need much looking after at the moment, but the staff are very good. I don't think they would do anything without my permission". A relative told us, "The staff are really good. They always keep us involved and let us know about developments straight away". A staff member explained what they would do if someone refused care and said, "I always ask them. I try sometimes to encourage them. If not, I come away and try later". Another member of staff referred to obtaining people's consent and explained, "It's about the way you talk to them. If someone refuses, we'd leave them and move on to another resident. You can't force anyone".

Care plans and daily records showed that people, or their representatives, had regular and formal involvement in care planning and risk assessment. All care plans and risk assessments were reviewed monthly and signed by staff and either the person or their representative(s).

We observed that people were treated with dignity and respect. We asked people and their relatives about this. One person told us, "They [staff] always knock before they come in my room and treat me with respect". Another person said, "I look on this room as my own property. I would expect someone to ask before coming in and they do". We asked people and their relatives how independence was promoted. One person told us, "I've noticed that staff will just let you get on with it if you can. I must admit at first I thought they were a bit lazy, but I can see now that's not the case. If you really need help, they are there". A relative told us, "My mum can do so much more now than before. I didn't think it was possible, but it's true".

People were supported at the end of their life to have a private, comfortable, dignified and pain-free death. Care plans contained a section which included advanced decision making. This section was completed in conjunction with people and their families. They included whether the person wished to be resuscitated in the event of cardiac arrest. The care plans for people who did not wish to be resuscitated contained documentation (Do Not Attempt Resuscitation forms) indicating this, as required by law and were countersigned by the person's GP. Staff displayed a good level of knowledge about advanced care planning and were aware of people's needs in this respect.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. We asked people if they felt person-centred care was delivered by staff at the home. They told us, "Yes, I do feel at the centre of things. I know them [staff] really well now and they know me". Another person said, "I don't feel like I'm a burden or just a patient. They [staff] really look after me well and know what I need".

Care plans and daily records were legible, up to date and personalised. They contained detailed information about people's care needs about how they wished to be cared for and supported by staff. Care plans contained information about people's personal histories, likes and dislikes. However, this was inconsistent. Some records documented detailed life and social histories for people, whilst others contained very little. People's choices and preferences were also documented, including whether they preferred to be cared for by male or female staff. The daily records showed that these were taken into account when people received care, for example, in their choice of food and drink. Staff confirmed they had read people's care plans. One staff member said, "I also ask a lot as well". They went on to explain their understanding of person-centred care and said, "Well, it's what they want, choices and things. The more you chat to them, the more you know them". Another member of staff confirmed they had access to care plans and explained how they familiarised themselves with people's care needs. They told us, "Some of it I see, quite a bit, I asked" and confirmed that handover meetings between shifts enabled them to ensure people's most up to date care needs were addressed.

People's needs were assessed and care and treatment was planned and delivered to reflect their individual care plan. Care plans were regularly updated in line with people's changing needs and at least monthly. There was good communication in the management of people's care between the provider and external professionals, such as GPs and community nurses. We observed this on the day of our inspection.

We asked people about the availability of social opportunities at the home. One person told us, "Yes, a lot is happening here, but you don't have to join in if you don't want to. I'm not sure people go out much, though it doesn't bother me". Another person said, "Well I don't want to join in at all. The staff know that now and they respect it".

The home did not have an activities co-ordinator, but the manager had taken on this role. On the day of our inspection, a visit had been organised from 'Owls Out and About'. This was a voluntary organisation who brought six owls along, so people could hold them if they wished and learn more about owls and their habitats. People were observed to be engaged with this activity, asked a variety of questions and enjoyed holding and stroking the owls. A range of activities had been organised for the month and a notice informing people about these was on display in the hall. These included games, quizzes, arts and crafts, sing-along sessions, music and reminiscence sessions.

We asked how people were consulted about the activities on offer and were told by staff that this was discussed with people on a one-to-one basis. However, no records were kept of this and no residents' meetings were held. Therefore, it was not possible to confirm that people and their families were involved in this process.

We asked relatives about how the home managed concerns and complaints. One relative said, "The manager is very open and honest. I couldn't ask for more". Another relative told us, "I haven't had cause for complaint, but I know the manager would listen".

The provider's complaints policy and procedures were displayed in the hall. The complaints policy included clear guidelines on how and by when issues should be resolved, usually within two weeks. However, it did not contain the contact details of relevant external agencies, such as the Local Government Ombudsman or the local authority. It did contain contact details for the Care Quality Commission, which does not investigate individual complaints. The complaints log confirmed that no complaints had been recorded within the year. We asked the manager about this and they said that people and their relatives were seen very regularly and issues tended to be dealt with before formal complaints procedures were invoked.

There had been five compliments cards left by relatives through the year. They expressed satisfaction in areas such as staff attitudes and the high levels of staff competency.

Requires improvement

Is the service well-led?

Our findings

The manager was in the process of building a fully trained and skilled staff team and felt that they had made some progress towards improving the service since coming into post. Care records had been reviewed and updated and the day-to-day management of the home had been improved with the introduction of daily checks to ensure that people received the care they needed. However, there were no systems or processes in place to measure the quality of care delivered and no formal audits were undertaken to ensure that all aspects of the service were fit for purpose. There were no systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of people at the home. For example, no formal audit had been undertaken to ensure that people received their medicines as prescribed. This meant that people may not have received their medicines when required because staff had not always completed the Medication Administration Record (MAR) accurately.

The above evidence shows that systems or processes had not been established to ensure compliance. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people and their relatives about their experiences of the culture of the home and the level of involvement they had in the day to day running of the service. One person said, "I don't get involved with that". A relative told us, "Well I know I can speak to the manager at any time, but I'm not sure if there's anything formal going on".

People and their relatives had little opportunity to be actively involved in developing the service. We asked the manager whether residents' and relatives' meetings were organised to enable people to share views and to feedback about the service. We were told that none had been recently held. However, the manager told us that she saw each person on a daily basis and that these informal meetings enabled people to air their views. She said that there were plans to hold a cheese and wine event in November, to which people and their families would be invited. Three satisfaction questionnaires had been completed by people about a month prior to our inspection. No other views had been formally sought from people and the manager said this would be introduced at a later date. The three completed questionnaires indicated a high level of satisfaction in areas such as staff attitudes, maintaining people's dignity and privacy and the quality of the food.

Staff were supported to question practice and were aware of the provider's whistleblowing policy. They told us that they would report any concerns they had to either the manager, the provider or to the Care Quality Commission. The manager said, "I've told staff they can ring me any time for advice and assistance"

The manager at Victoria Royal Beach had been in post for three months and had not yet completed her probationary period with the provider. She told us that once she had successfully completed her probationary period, she would arrange to register as manager with the Commission. She told us that she felt supported by the provider who visited the home two or three times every week and there was daily contact by telephone The manager felt that recruiting staff to deliver the service had been a challenge and added, "I just want rooms to be ready. I like things well done".

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not provided in a safe way for service users. The provider did not have systems in place to ensure the proper and safe management of medicines. Regulation 12(1)(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems or processes had not been established or operated effectively to ensure compliance. The quality and safety of the services provided had not been assessed or monitored. There were no systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of people and others who may be at risk. Regulation 17 (1) (2)(a)(b)