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Victoria House Residential Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service in November 2015. Breaches of legal requirements were found and we rated the service as "requires improvement". After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. On this inspection we found that the provider was no longer in breach of the regulations.

This inspection took place on 30 January 2017 and was unannounced.

Victoria House is registered to provide accommodation for personal care for up to 20 older people or people living with dementia or a physical disability. There were 12 people living at the service on the day of our inspection.

The service was managed by the registered provider. Registered providers are 'registered persons'. Registered persons have the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect them. The management and staff understood their responsibility and made appropriate referrals for assessment. Six people living at the service had been referred to the local authority DoLS team and were waiting on assessments to have their freedom lawfully restricted under a DoLS authorisation.

Staff undertook appropriate risk assessments for all aspects of a person's care to keep them safe from harm. Care plans were developed to support people's individual needs. Staff knew what action to take and who to report to if they were concerned about the safety and welfare of the people in their care. People received their prescribed medicine safely from staff that were competent to do so. The provider ensured that there were always sufficient numbers of staff on duty to keep people safe.

People were supported to have a healthy and nutritious diet and hot and cold drinks and snacks and fresh fruit were available throughout the day. People had their healthcare needs identified and were able to access healthcare professionals such as their GP and dentist. Staff knew how to access specialist professional help when needed.

People were at the centre of the caring process and staff acknowledged them as unique individuals. People who lived at the service told us that staff were kind and caring and we saw examples of good care practice. People were always treated with dignity and respect. People were cared for by staff that were supported to undertake training to improve their knowledge and advance their skills to enable them to perform their roles

and responsibilities effectively.

People were supported to have an active life and were encouraged to take part in hobbies and interests of their choice. However, there was not an activity coordinator in post. Relatives commented that their loved ones were well looked after.

People where able, were supported to make decisions about their care and treatment and maintain their independence. People and their relatives had access to information about how to make a complaint. Relatives told us that they could approach staff with concerns and knew how to make a formal complaint to the provider.

The provider had introduced robust systems to monitor the quality of the service and make improvements. Staff had access to professional development, supervision and feedback on their performance. People, their relatives and staff found the provider and their deputy approachable.

Overall, we found that the provider had led their team to introduce and sustain improvements to the service, such as good infection control practices and monitoring the quality and safety of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People had their risk of harm assessed for all aspects of their care. Staff were aware of safeguarding issues, knew how to recognise signs of abuse and how to raise concerns.

There were sufficient numbers of staff on duty to keep people safe.

The service was clean and staff had access to hand washing facilities and protective equipment.

Medicines were ordered, stored, administered and disposed of safely. Staff were assessed as competent to administer medicines.

Is the service effective?

Good

The service is effective.

Staff had received appropriate training, and understood the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were cared for by staff that had the knowledge and skills to carry out their roles and responsibilities.

People were supported to have enough to eat and drink and have a balanced diet.

Staff ensured people had their healthcare needs met by appropriate healthcare professionals.

Is the service caring?

Good

The service is caring.

Staff had a good relationship with people and treated them with kindness and compassion.

Where able people were involved in decisions about their care.

People were treated with dignity and staff members respected their choices, needs and preferences.

Is the service responsive?

Good

The service is responsive.

People's care was regularly assessed, planned and reviewed to meet their individual care needs.

People were encouraged to take part in hobbies and interests when they were available.

People had a say in the running of the service through regular meetings.

Is the service well-led?

Good

The service is well-led.

The provider had completed regular quality checks to help ensure that people received safe and appropriate care.

There was an open and positive culture which focussed on people and staff.

People who lived in the service and their relatives found the provider and deputy manager approachable.

Positive change had been implemented in response to our last inspection.

Victoria House Residential Home

Detailed findings

Background to this inspection

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

The inspection took place on 30 January 2017 and was unannounced. The inspection team was made up of one inspector and an expert by experience.

An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We did not ask the provider to complete a Provider Information Return (PIR) before our inspection. This was because we were following up on previous breaches of the regulations.

We looked at information we held about the provider. This included notifications which are events which happened in the service that the provider is required to tell us about.

During our inspection we spoke with the provider, the deputy manager, two members of care staff, the chef, the housekeeper, who also covered maintenance duties and eight people who lived at the service and four visiting relatives. We also observed staff interacting with people in communal areas, providing care and support.

We looked at a range of records related to the running of and the quality of the service. These included tow staff recruitment and induction files, staff training information, meeting minutes and arrangements for managing complaints. We looked at the quality assurance audits that the provider had completed. We also looked at care plans for five people and eight medicine administration records.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who were unable talk with us.

Good

Is the service safe?

Our findings

At our previous inspection in November 2015 we identified that standards of cleanliness were not always maintained throughout the service and there was a risk of cross contamination from soiled and damaged equipment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan which set out how they planned to address the areas highlighted.

On this inspection we found that the service was clean and people were no longer at risk of cross contamination from soiled and damaged equipment. The provider was no longer in breach of the regulation.

Several areas of the service had been redecorated and recarpeted since our last inspection. People told us that they had been involved in choosing the decoration. This provided a much improved environment and the service had a homely feel to it. We saw that there were generous supplies of protective equipment, such as aprons and gloves in most areas of the service and that staff used them appropriately. Hand gel dispensers were easily accessible throughout the service. We saw that the provider had introduced an information board on infection control and cleanliness. This was accessible to all staff.

The service did not have a sluice for the safe disposal of body waste. However the deputy manager explained the processes in place to handle commode basins or urinals safely to prevent the risk of cross contamination from splashes from body fluids during waste disposal and cleaning procedures.

We spoke with a member of the housekeeping team who told us that they now had daily, weekly and deep cleaning schedules and that these were signed on completion of a cleaning task. We looked at the cleaning schedules and checklist for the previous week and saw that all cleaning duties had been signed as completed. The housekeeper also informed us that they had been trained in the safe use and storage of cleaning products. The cleaning products were stored securely in a locked cupboard and housekeeping staff had guidance of the safe use of cleaning products such as detergents and toilet cleaner. The housekeeper told us that they worked opposite days to another housekeeper and they shared the tasks. However, one day a week they worked together and that was when the deep cleaning was undertaken. This was confirmed by the deep cleaning records.

At our previous inspection in November 2015 we identified that the provider did not ensure that there were sufficient numbers of suitably qualified, competent and experienced staff on duty at night. Staff were not always supported to undertake training to improve their knowledge and skills and did not receive regular feedback on their performance. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan which set out how they planned to address the areas highlighted.

On this inspection we found that the provider had reviewed their duty rota to ensure that there were enough suitably qualified, competent and experienced staff on duty at night. In addition, the provider supported staff to undertake training pertinent to their role and provided feedback to staff on their performance. For example, night staff have since been trained in medicine management and had their competency assessed. This meant that there was no longer a risk that people would have to wait for the on-call manager to come in if the person needed pain relief or any other as required medicine. The provider was no longer in breach of the regulation.

We found that there were sufficient numbers of staff on duty to meet people's needs and call bells were answered promptly. One person who lived at the service told us, "If I press my buzzer they come very quickly, it's never a problem. To be fair, the staff work very hard and do long shifts, they do very well." One person's relative said, "They always seem very busy, but I think there is always sufficient staff on [duty]. I never hear any buzzers going for very long. If at all."

We looked at two personnel files for staff and saw that there were robust recruitment processes in place that ensured all necessary safety checks were completed to ensure that a prospective staff member was suitable before they were appointed to post. We spoke with two recently appointed members of staff who told us about their induction. One member of staff said, "I shadowed [name of deputy manager] for the day. They also took me through my induction, sorted me out with training. Showed me where things are, like the policies and told me all about infection control." Another staff member told us, "I have a good induction with [name of deputy manager] and I've had supervision too." Everyone [staff] have been so supportive."

The relatives of people who lived at the service told us that Victoria House was safe place to live. One person's relative said, "I am very happy with my family member being here and I know they are safe and they are happy and settled. I wouldn't have it any other way." Another person's relative told us, "It's as good as its going to get. I feel my loved one is as safe as houses here." In addition, relatives were aware that staff had the skills to keep their loved one safe. For example, one person's relative commented. "I think they manage the residents safely. I think they have training in it." We saw that the visitors guide introduced in July 2016 contained information on to raise awareness of safeguarding."

The provider had policies and procedures in place to support staff to prevent people from avoidable harm, potential abuse and help keep them safe. Staff told us that they had received training on how to keep people safe and knew how to recognise signs of abuse and how to escalate their concerns. One member of staff told us, "It's about safeguarding vulnerable people against their family, staff and people outside the home mistreating them. I would report it straightaway to CQC, social services and my manager." Another member of staff said, "If I'm unhappy with the way things are being done to people, there is a [telephone] number on the board in the kitchen to phone."

There were systems in place to support staff when the provider or manager was not on duty. Staff had access to an emergency folder that contained contingency plans to be actioned in an emergency situation such as a fire or electrical failure. Staff had access to on-call senior staff out of hours for support and guidance and the provider and their deputy lived less than five minutes' drive from the service. Furthermore, people had an up to date individual emergency evacuation plan to be used to help them leave the premises safely in an emergency situation, such as a fire.

People had their risk of harm assessed. We found that a range of risk assessments had been completed for each person for different aspects of their care such as falls and nutrition. Care plans were in place to enable staff to reduce the risk and maintain a person's safety. For example, we spoke with one person who was registered blind and was unable to use their call buzzer and was at risk of falls if they stood up from their

chair unaided. A sensor alarm was in place on the wall opposite the person's bed and armchair. The person shared with us that when they required assistance they waved their arm, the sensor triggered an alarm and staff were alerted to their request.

People received their medicine from staff that had received training in medicines management and had been assessed as competent to administer them. At breakfast time we observed medicines being administered to people and noted that appropriate safety checks were carried out and the administration records were completed. The member of staff administering medicines told us that they had completed medicine management training and had their competency checked before they were permitted to administer medicines unsupervised.

All medicines were stored accordance with legal requirements, such as locked cupboards, medicines trolleys and fridges. There were processes in place for the ordering and supply of people's medicines to ensure they were received in a timely manner and out of date and unwanted medicines were returned promptly. Staff had access to guidance on the safe use of medicines and the medicines policy.

We observed that when a person who had difficulty swallowing and was at risk of choking that care staff assisted the person to sit upright in bed to ensure that they swallowed their medicines safely. We looked at medicine administration records (MAR) for eight people and found that medicines had been given consistently and there were no gaps in the MAR charts. Each MAR chart had a photograph of the person for identification purposes and any allergies and special instructions were recorded. Where a person did not receive their medicine a standard code was used to identify the reason, such as when a person was asleep.

When a person was prescribed medicine to be taken once a week this was clearly identified on their MAR chart. However, we did bring to the deputy manager's attention that there was not a stop date for a people who were receiving a short course of antibiotics.

Good

Is the service effective?

Our findings

People and their relatives told us that staff had the knowledge and skills to carry out their roles and responsibilities. One person's relative said, "I think the staff are trained as you would expect really. I am sure the manager ensures they are trained, otherwise they wouldn't let them do things would they."

Staff were provided with mandatory training such as health and safety, food hygiene and fire and also training specific to people's individual needs, such as the care of a person living with dementia. We saw that staff from all disciplines were provided with training pertinent to their specialism. For example, a member of the catering staff was undertaking a nationally recognised qualification in cooking. The provider gave the same opportunities to all members of staff to improve their knowledge and understanding regardless of their previous experience. A recently employed member of staff told us that they had not studied for any qualifications since they left school. Therefore, they spoke positively that were provided with the opportunity to undertake a Mathematics and English foundation course before they were enrolled on nationally recognised qualification in their speciality.

We saw that some staff had been nominated as lead person for key topics. For example, the deputy manager was the link nurse for infection control and attended regular peer group meeting arranged by the local authority. They then supported other staff to maintain safe infection prevention and control practices.

Staff received regular supervision and appraisals and said that they were a positive experience and they welcomed feedback on their performance. One member of staff said, "I have an appraisal every six months. Just had one before Christmas. Everything was fine." Another member of staff told us, "I had my first appraisal two months ago. I was asked if I was treated fairly and if I liked my job." We looked at pre-appraisal self-assessment forms completed by two members of staff. We noted that staff had insight into their learning and development needs and there was a record of their progress.

We observed that people's consent to care and treatment was sought by staff. For example, we saw that people had given their signed consent to have their photograph taken for identification purposes, to receive care and for staff to share their information with other health and social care professionals. We saw were one person had the capacity to make decisions, but was not physically able to sign their consent that this was clearly recorded on the consent forms. Where a person lacked capacity to give their consent staff followed the principles of the Mental Capacity Act 2005 (MCA).

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. A member of care staff said, "Sometimes they are unable to tell us what they want and we have to make that decision for them, but it's always in their best interest."

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the provider had followed the requirements in the DoLS and six applications had been submitted to the local authority and were waiting on assessments.

The provider had properly trained and prepared their staff in understanding the requirements of the MCA and DoLS. In addition, staff had the support of the provider and deputy manager who were the designated MCA and DoLS leads for the service.

People were provided with a well-balanced and nutritious diet. In addition, hot and cold drinks and snacks were provided throughout the day and a selection of fruit was available in the main lounge and we saw people helped themselves to this. This area of the lounge was referred to as the snack and refreshment zone. We saw that there were information leaflets in both word and picture format available on eating and drinking well.

People and their relatives told us there was always plenty to eat and drink and that the food was always good. One person said, "The chef is very good and he comes and sees us and checks what we would like to eat. He's lovely. Like today, I had jelly instead of the upside down pudding." One person's relative said, "The food is good and it always smells good and I know it's freshly made. They have a good cook." Another person's relative said, "The chef is very good. He comes and cheers us up. He makes my loved one bacon butties which they love. The chef does special things that makes my loved one feel good." We saw the cook spend time chatting with people after they had finished their main course. They cook told us that they liked to get feedback from people on the quality of their meal.

The chef told us that they catered for people with special dietary needs and were aware of any food allergies people may have or any foods that may react with their medicine. For example, some people were offered an alternative to broccoli at lunchtime because it would interfere with the effectiveness of their blood thinning medicine. We saw a record of people's individual food likes and dislikes and food allergies. The chef told us that they did not attend resident meetings to discuss food preferences and changes to menu plans. We shared this with the provider who said that the chef would be invited to all future meetings.

Food charts were not completed routinely. The deputy manager told us that a food chart was only completed on days when a person did not want to eat or if their appetite was poor. We discussed the benefits of maintaining a food chart over consecutive days to paint an overall picture of a person's intake to identify if they needed a referral to a dietician. The deputy manager said that they would change the way they currently did things.

People were supported to maintain good health. We saw that people had access to healthcare services such as their GP, district nurse and dentist. Relatives told us that they were reassured that staff would call their loved one's GP if needed. One relative said, "I know they are very quick to call the doctor if anyone ever needs any medical attention." We saw that a GP had visited one person in response to a request from care staff and saw that the medicines had been reviewed. We evidence that people had regular health checks and were provided with flu and pneumonia annual vaccinations. We saw evidence that if a person presented with signs of fever, such as a high temperature or a urine infection that staff had a screening tool to detect early signs of sepsis. This meant that people received timely and appropriate treatment from their GP.

Good

Is the service caring?

Our findings

People told us that they were looked after by kind, caring and compassionate staff. We observed staff interacting with people and saw that people and staff had a good relationship and there was lots of friendly banter. One person's relative told us, "It is more a home from home here. My relative is very well looked after. The owner is very good. The do keep me well informed and always ring if there is anything I should know." Staff told us that they treated people the way they would like to be treated.

We saw measures in place to enable people to be orientated to the day of the week and to their surroundings. There were written and pictorial signage on the doors to all public areas such as the lounge and toilets. People passed through the main reception hall on their way to the public rooms, and we noted that a weather chart, calendar and clock were on display. We also noted that all of the clocks in the service were at the correct time.

For example, most bedroom doors looked the same. Therefore, some people had a familiar photograph on the outside of their bedroom door to help them recognise their bedroom and reduced the risk of becoming distressed if they were unable to find their bedroom. Pictorial menus were on display at the entrance to the dining room and this helped some people to make their choice at mealtimes.

We saw further initiatives to support people with memory difficulties had been introduced since our last inspection. Most bedrooms had been refurbished with furniture specifically design to enable people with memory loss to recognise their clothing and other personal items and reduce their risk of becoming anxious or distressed. Every drawer and cupboard had an area cut away that served as an easy grip handle and people were also able to see into the drawer. The colour of the wall decoration was in contrast to the new bedroom furniture and further helped people with perception difficulties.

We observed staff assist some people to the dining room for their lunch. People were supported to walk at their own pace and staff chatted with them in a friendly manner. We saw that most people sat in friendship groups to have their lunch. We observed that lunchtime was a positive experience. The tables were set with pictorial placemats and napkins. Were a person was a risk of soiling their clothing with food spills staff assisted them to wear a protective tabard.

People had care plans tailored to meet their individual needs and they were encouraged to take part in reviews of their care plans. People had their health and well-being reviewed by staff once a month. This included the condition of their skin, their weight and their ability to move about the service safely.

We found where a person was unable to communicate their needs verbally that staff still enabled them to make decisions. For example on person's relative told us how staff helped their loved one choose the clothes they would wear and said, "They care for [Name of person] very well. She chooses what she wants to wear. They hold two choices for her and they smile at the one she wants to wear." We also saw that the important information, such as service user guide came in a large print format to help people with visual difficulties.

People who lived at the service told us that staff treated them with respect. One person said, "They are all very courteous and treat me with dignity and respect." The relatives we spoke with said that staff treated their loved one with dignity and respect. One person's relative told us that staff were always courteous and said, "I've never heard staff say anything untoward, but if they did I would do something about it," they continued to say, "There is a calm and quiet about this place."

We saw that people's right to their privacy and personal space was respected. For example, we noted that staff always knocked on a person's bedroom door before entering and said good morning. Furthermore, bedroom doors and curtains were closed when a person was receiving personal care.

We observed that care and catering staff took a dignified approach at lunchtime. We found that when a person had their meals pureed that all food ingredients were presented separately and their meal looked appetising. We observed a member of care staff enable a person living with dementia to maintain their independence and eat their meal unaided. Although the person ate their meal at a slow pace, they were not rushed and care staff acknowledged the person's achievement.

People were provided with information on how to access an advocate to support them through complex decision making, such as moving into the service permanently. Advocacy services are independent of the service and local authority and can support people to make and communicate their wishes.

Good

Is the service responsive?

Our findings

People had their care needs assessed and personalised care plans were introduced to outline the care they received. Care was person centred and focussed on the needs of the person. People and their relatives were involved in planning their care. We saw that individual care plans focussed on supporting a person to live well and maintain their independence.

Relatives spoke of their involvement with the care plans and one said, "I'm aware they right things about [Name of relative]. I just wasn't sure what it was called." We saw that people had a section in their care file called, 'This is me'. This was a personal profile that provided staff with personal information about the person's likes, dislikes and preferences. For example, we saw that one person like to have a bath and their hair washed on a Thursday. We noted that some of the personal profiles were in picture and word format. We looked at the daily care records as saw that they were cross referenced to the care plans and any accident or incident forms. For example, we read that one person was unsteady on their feet, and recently had a fall. Care staff were now encouraging the person to use the stair lift. We also noted that the provider had introduced a discreet code on the front cover of care files. This identified important information, such as if a person had difficulty hearing or was partially sighted.

We found that people were encouraged to spend their time how and where they wished. We spoke with one person in their bedroom. They told us, "I tend to stay in my room. It's my choice. I take my meals in here and I do get a lot of visitors." We saw that most people chose to sit in the quiet sitting room to read a book or magazine and others enjoyed watching television in the main lounge. We spoke with the relative of one person who liked to pass their time in the quiet room who said, "My [name of relative] likes the little lounge. It's very homely and I'm sure she feels very safe in there and I know she is happy and settled. I have nothing but praise for them here [staff]." The relative went on to talk about recent improvements to the environment and said, "Things have been improving with lots of decoration and with the new extension. It's very reassuring. There is new carpet in the sitting room and I think they have tried to decorate it as the older generation would like to see it." We saw that the sitting room had been decorated and furnished since our last inspection in the style of a family sitting room."

There was a conservatory where people could choose to take their meals. However, it was also used as an activity room. We saw that there were materials for arts and crafts and board games and puzzles. The service did not have a designated activity person. We were told by the provider and members of care staff that they arranged activities with people after lunch. We saw that there was a weekly programme of events. Although we saw evidence of different art and craft pastimes, several people told us that they would like more activities. One person said, "We spend too much time sat on our backsides." Another person said, "We don't have lots of things going on, but we did have a Christmas party." The provider told us that care staff supported people with activities and often relatives offered their assistance. However, they were looking to recruit a permanent activity coordinator. Members of care staff shared with us the recent activities that they had engaged people in and the impact they had on people. One staff member said, "We made play dough last week. It was amazing to see how people with dementia, some of them quite severe made things with it. They really enjoyed the play dough."

Photographs of activities people had recently taken part in were on display in the conservatory. We also saw a poster in the lounge of people's painted hand prints. We spoke with people who told us that they enjoyed taking part in the activity.

We noted that significant improvements had been made to the grounds since our last inspection. For example, there were raised beds, new furniture and secure fencing.

People were supported to maintain their links with the local community and their relatives. For example, one person had gone out for lunch into the local town with their relative. We saw that some people took advantage of a local voluntary driver scheme that enabled them to have trips out. One person told us that the people from the church visited now and then.

Some people invited us to look at their bedroom. We found that they were supported to personalise their bedroom with items from home such as pieces of furniture, photographs and keepsakes. Rooms that had previously been shared rooms were now only allocated for single occupancy. We saw that the five bedrooms in the extension were decorated and furnished to a high standard and had the space to comfortable accommodate a wheelchair and a hoist if needed. There was also a small sitting area in this wing.

We saw that staff exchanged information about a person's care needs and wellbeing at shift handover to maintain continuity of person centred care.

People and their relatives had access to information on how to make a complaint. For example, we noted that guidance on making a complaint and how to contact the local government ombudsman was in the service user's guide and the visitor's hand book. However, people and their relatives told us that they had no cause to complain. People and their relatives told us that they had no reason to complain and could talk with staff at any time. One person's relative said, "If I wasn't happy the owner would definitely sort things out they are a very good person." Staff told us that if a person complained to them they would escalate the concern to the provider or their deputy.

People were invited to regular meetings to share their views on the service. We read the minutes from the last residents' meeting held on 2 December 2016. We saw that seven people had attended. Much of their discussion was about the events planned over the Christmas period, such as people wanted to make their own mince pies, the Christmas party and visit a planned visit from singers of the local grammar school. In addition, people provided positive feedback on the completion of the new extension.

Good

Is the service well-led?

Our findings

At our previous inspection in November 2015 we identified that the provider did operate effective systems and processes to make sure that they assess and monitor the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan which set out how they planned to address the areas highlighted.

On this inspection we found that the provider had introduced systems and processes to measure the effectiveness and quality of the service. The provider was no longer in breach of the regulation.

The provider kept people and their relatives aware of any changes to the service. For example, people and their relatives were invited to meetings during the construction of the bedroom extension to keep them up to date with its progress. All staff attended regular team meetings with the provider and deputy manager. One member of staff told us that they discussed issues relevant to the people who lived in the service.

The provider told us that following their last inspection report they wanted to raise the profile of the service within the local community and share what life was like at Victoria House. Therefore local residents and health and social care professionals were invited to an open day in November 2016. They said that the event was a success and people who lived in the service enjoyed it.

People who lived at the service, their relatives and staff were invited to give their feedback on the service through a satisfaction questionnaire. We read the most recent returns and saw that the feedback was positive and people were happy with the quality of the care they received.

One person's relative spoke positively about the leadership and management of the service and said, "They have a good relationship with the residents. I think the owners run a tight ship which is good. Recently things have been improving with lots of decoration and the building of the extension. It's very reassuring." Another relative said of the deputy manager, "They are very good. They keep staff on their toes and are very caring. It's very reassuring knowing that they are on duty."

Staff told us that the provider and the deputy manager were approachable and supportive. One member of care staff commented, "[names of provider and deputy manager] are very approachable. We all work in partnership with each other."

We found that the provider and their deputy were visible leaders, knew their staff and the people in their care. The people and their relatives that we spoke with knew who the provider and deputy manager were and knew them by name.

A care staff handbook had been introduced in July 2016. This provided staff with useful information, such as the aims and objectives of the service, their duty of care towards people who lived at the service and guidance on key areas, including whistleblowing. Staff told us that they were a good team and that they

were proud to work in the service. One staff member said, "This home is good enough for my mum."

Staff had access to policies and procedures on a range of topics relevant to their roles. For example, we saw policies on safeguarding and infection control and guidance on delivering personal care. Staff were aware of the whistle blowing policy, knew where to find it and knew how to raise concerns about the care people received with the staff member in charge. We discussed a recent safeguarding concern with the provider, looked at the person's care file and found that concerns raised had been fully investigated and appropriate actions had been taken. The provider kept a log of all accidents and incidents that occurred in the service with the outcomes and any follow up treatment or action. Incidents, concerns and lessons learnt were shared with staff.

A programme of regular audits had been introduced since our last inspection. This covered key areas such as health and safety, medicines and infection control. Action plans with realistic time scales were produced to address any areas in need of improvement. For example, a faulty commode had been identified on a bedroom audit and this had been replaced. The audit outcomes and required actions were shared with staff. Staff had access to up to date information on key topics such as safeguarding, mental capacity and dignity.