Sharda Care Limited

Victoria Care Centre

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This unannounced comprehensive inspection of Victoria Care Centre took place on the 12 and 13 May 2016.

At our last inspection of this service on 5 November 2015, two breaches of legal requirements were found. These related to the management of risks to the health and safety of people and a shortfall in the maintenance of accurate complete records to do with the care and treatment provided to people. During this inspection we found the provider had followed their action plan, and now met legal requirements by having arrangements in place to manage risks to the health and safety of people using the service and maintaining accurate records in respect of the care and treatment provided to people.

Victoria Care Centre is a care home that provides personal care and accommodation for 115 people some of whom have dementia or physical disabilities. At the time of our inspection there were 113 people living in the home.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission [CQC] to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act [HSCA] 2008 and associated Regulations about how the service is run.

People were treated with respect, and staff engaged with people in a friendly and courteous manner. People told us staff were approachable, listened to them, respected their privacy and were kind. Throughout our visit we observed caring and supportive relationships between staff and people using the service.

People told us they felt safe. Staff understood how to safeguard the people they supported. People's individual needs and risks were identified, managed and reviewed as part of their plan of care and support. Care plans had recently been reviewed and were personalised and reflected people's current needs. They contained the information staff needed to provide people with the care they wanted and needed. However, we found some deficiencies in the management and administration of medicines.

People were provided with choice and their decisions respected. They had the opportunity to participate in a range of activities and were provided with the support they needed to maintain links with their family and friends.

Staff had an understanding of the systems in place to protect people if they were unable to make one or more decisions about their care, treatment and other aspects of their lives. The registered manager knew about the legal requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). DoLS were in place when it was necessary to restrict people's freedom in some way. However, some staff were unclear about their responsibilities regarding the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and their implications for people living in the home.

People were supported to maintain good health. They had access to appropriate healthcare services that monitored their health and provided treatment and advice when people were unwell. People were supported to maintain their mobility. People's nutritional needs and special dietary requirements were understood and catered for by staff.

Staff were appropriately recruited, trained and supported to provide people with the care they needed. Staff told us they enjoyed working in the home and received the support they needed to carry out their roles and responsibilities.

People knew how to raise concerns and complaints if they needed to. Appropriate action was taken to address issues that were raised. People's views of the service were sought and responded to appropriately.

There were systems in place to regularly assess, monitor and improve the quality of the services provided for people. Some areas of quality assurance were in the process of being developed and improved.

We found one breach of the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

There were areas of the service that were not safe. We found some deficiencies in the management and administration of medicines.

People told us they felt safe and were treated well by staff. Staff knew how to recognise abuse and understood their responsibility to keep people safe and protect them from harm.

Risks to people were identified and measures were in place to protect people from harm whilst promoting their independence.

Appropriate recruitment and selection processes were carried out to make sure only suitable staff were employed to care for people. The staffing of the service was organised to make sure people received the care and support they needed and wanted.

Is the service effective?

Good

The service was effective. People were cared for by staff who received the training and support they needed to enable them to carry out their responsibilities in meeting people's individual needs.

People were provided with a choice of meals and refreshments that met their preferences and dietary needs.

People were supported to maintain good health. They had access to a range of healthcare professionals to make sure they received effective healthcare and treatment.

People were supported to make decisions for themselves and, when they were unable to do so decisions were made in their best interests. Any restrictions to people's liberty were appropriately authorised. However, some staff were unclear about their responsibilities regarding the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and their implications for people living in the home.

Is the service caring?

Good

The service was caring. People were treated with dignity and

kindness. Staff understood and respected people's rights, views and wishes.

Staff respected people's right to privacy and had a good understanding of the importance of confidentiality.

People's well-being and their relationships with those important to them were promoted and supported.

Is the service responsive?

Good

The service was responsive. People received personalised care and support which was responsive to changes in their needs and wishes.

People's religious, cultural and individual needs were respected and accommodated.

There was a system in place for peoples' complaints to be listened to and addressed. Staff understood the procedures for receiving and responding to concerns and complaints. People knew who they could speak with if they had a complaint.

Is the service well-led?

Good

The service was well led. The management of the home was open and inclusive. Staff reported they felt able to raise issues about the service, which they were confident would be addressed appropriately.

People had the opportunity to provide feedback about the service and issues raised were addressed appropriately.

There were processes in place to monitor the quality of the service, identify any issues that needed to be addressed, and improvements were made when needed.

Victoria Care Centre

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 was carried out by two inspectors, one inspection manager, a nurse specialist advisor, a pharmacist specialist advisor 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. Before the inspection we looked at information we held about the service. This information included notifications sent to the CQC and all other contact that we had with the home since the previous inspection. Prior to the inspection we looked at the Provider Information Return [PIR] which the registered manager had completed before the inspection. The PIR 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. The PIR was discussed with the registered manager following the inspection.

During the inspection we spoke with 27 people using the service. Some people had difficulty in describing their experience of living in the home due to their significant health and communication needs, so to gain further understanding of people's experience of the service we spent time observing how they were supported by staff. We also used the short observational framework for inspection [SOFI] tool, which is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we spoke with the registered manager, deputy manager, clinical lead, two directors, human resources assistant, finance manager, four unit managers, four nurses, facilities manager, housekeeping manager, a chef, activities co-ordinator, 15 senior care workers and other care staff and a health professional. We spoke with relatives and visitors during the inspection. Following the inspection we received feedback about the service from two social care professionals.

We also reviewed a variety of records which related to people's individual care and the running of the home. These records included; care plans of people living in each unit of the home, five staff records, audits, and policies and procedures that related to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People using the service who were able to communicate effectively said they felt safe in the home. A person told us "The staff are nice. I feel safe here." The relatives spoken with said they believed people were safe living in Victoria Care Centre. They told us "[Person] is absolutely safe," and "Yes, my relative is safe here-definitely!"

At our last inspection on the 5 November 2015 the provider had not taken appropriate steps to ensure people were protected from the risks to their health and safety and there were shortfalls in the maintenance of accurate complete records. This meant the provider was in breach of Regulation 12 HSCA (Regulated Activities) Regulations 2014 and Regulation 17 HSCA (Regulated Activities) Regulations 2014.

Following the inspection the provider sent us an action plan setting out the actions they would take to meet the regulation. At this inspection, the provider had followed their action plan and met the regulations. People's risk assessments were accessible and had been reviewed and developed to include more detail. Staff we spoke with were aware of people's risk assessments. At the last inspection this information had been in electronic and/or written format which had led to information about people not always being accessible and accurate which put people at risk of not receiving the care and treatment they needed. During this inspection we found peoples' care plans had been reviewed and improved and these and other information about people were now in one format. Staff we spoke with were positive about the changes to the care plans and confirmed that information about people was accessible and included the detail they needed to provide people with the care and treatment they required.

We viewed the medicines in the four units of the service. People had their current prescribed medicines accurately recorded on their Medicines Administration Record (MAR) and the records correlated with the copy prescriptions and hospital discharge letters. Where a person was fed by a feeding tube into their stomach [enteral feeding], liquid medicines were prescribed when appropriate and for others swallowing guidelines which for some people included giving medicines covertly were available.

We observed medicines given to 6 people after their breakfast. We saw that they were explained and given with gentle encouragement. One person had been assessed as needing their medicines given covertly but we saw nurses communicate so well with them that the person took them slowly with thickened water. A person refused their medicines but the nurse calmed them and returned after 10 minutes and gently gave them to the person using the service. For another person, their blood pressure chart and bowel chart were referred to by the nurse administering medicines to check if a laxative and/or blood pressure tablet should be given. A relative said they were satisfied with the way medication was administered to their family member and a person using the service told us they were happy with the way their medicines were managed and administered.

On two units (2 and 4) we saw no omissions in recording administration on the MAR and all counts of medicines tallied with the records. Both units were carrying out regular stock counts and were showing examples of good practice. One unit produced a report to the supplying pharmacist at the end of each cycle

detailing changes in medicines dosages, discontinued medicines and excess stock of 'as required medicines'. The other unit filed information leaflets for each person's medicines with the MAR and used the daily ward meeting as an opportunity to focus on one person using the service including their medicines needs as a learning exercise for staff. However, on the other two units we found some omissions in the MAR. On unit 3 we looked at 15 MAR and we saw one person's medicines had not been signed as given on the morning of the inspection. For a course of antibiotics two doses were not recorded as given on 11/5/16 and when we tried to reconcile stock and records we found there were a total of three doses not given. For another person there were three gaps for administration of eye drops. On unit 1 we found just one gap but a stock count inferred that the medicine had been given. During a further 11 audits of MAR we found for one person there was one tablet remaining for one antipsychotic medicine and three tablets left for another similar type of medicine indicating these medicines may not have been administered. If medicines are not given as prescribed a person's health can be put at risk.

Although we saw two people's MAR charts indicated when they had been away from the home on leave, on review of the homes medicines policies and procedures we saw that the administration of leave medicines was not included in the policies. A further omission in the home's policies and procedures was for the managing of people's medicines when they were prescribed as required. Throughout the home there were prescriptions for as required rectal diazepam for controlling seizures, pain relief and medicines prescribed for agitation or sleep disturbances. However, we saw no individual protocols to enable nurses to know when, how often and in what circumstances these medicines should be given, particularly when the person lacked cognition, which could put people at risk of unsafe care and treatment.

These shortfalls in the management of medicines are a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were policies and procedures in place, which informed staff of the action they needed to take to keep people safe, including when they suspected abuse. Staff we spoke with were able to describe different kinds of abuse and aware of the whistleblowing procedures. Staff told us they would immediately report any concerns or suspicions of abuse to the unit manager and/or registered manager and these would be addressed appropriately by them. Staff knew that they would need to report any allegation of abuse to the local authority safeguarding team if the registered manager, unit manager and/or other senior staff including nurses did not do so. Staff informed us they had received training about safeguarding people and training records confirmed this.

The finance manager told us small amounts of money including people's personal allowances were kept in the home for people to access when they wished. Some people managed their own money but most people had their finances managed by their relatives or the local authority. Those who managed people's money were provided with a monthly statement of the person's finances and were invoiced following expenditure for personal items and services such as hairdressing and chiropody. We saw itemised receipts of spending and other appropriate records were maintained of people's finances.

The registered manager told us about the arrangements for managing and monitoring the staffing of the service to make sure people received the support they needed from sufficient numbers of skilled staff to keep them safe. The registered manager informed us the numbers and skill mix of staff were adjusted to meet the numbers and needs of people using the service. He told us that he was planning to put a specific tool in place to help him make sure there were always enough staff on duty to ensure people's varied needs were always met. He showed us some records of staffing levels in the home which matched [and was better in some areas] the safe staffing levels guidance developed by an organisation that has a role in promoting good nursing practice. Staff we spoke with told us they mostly worked on a specific unit to ensure there was

consistency of staff who were familiar to people using the service and understood their individual needs.

During the two days of inspection we found that although staff were busy there was no indication that there was insufficient staff. Staff were constantly present in the lounges and other areas of each unit. There were enough staff on duty to attend to people who remained in their rooms. People's call bells were answered promptly and staff had time to sit and talk with people and support them to participate in activities. Most people we spoke with said that staff were responsive and would respond appropriately when they pressed their call bell. However, people told us the response time varied. A person told us "They answer my bell, I don't wait too long." Two people said that it sometimes took staff several minutes to respond to call bells. A person commented "They're sometimes short-staffed at weekends." Another person told us "They [staff] don't have time to chat they're too busy." A person confirmed staff answered their call bell during the night. A member of staff responded promptly when we activated a call bell. This indicated there were sufficient staff on duty to be responsive to people's needs.

The five staff records we looked at showed appropriate recruitment and selection processes had been carried out to make sure only suitable staff were employed to care for people. These included checks to find out if the prospective employee had a criminal record or had been barred from working with people who needed care and support. We were informed that checks were carried out by phone and/or email to establish that staff references were authentic, however this action was not currently recorded.

Care plans showed that risks to people were assessed and guidance was in place for staff to follow to minimise the risk of the person being harmed and to support people to take some risks as part of their day to day living. People's risk assessments included guidelines for staff to follow to manage each risk and detailed the preventative action to be taken to lessen the risks of people falling, being harmed when equipment such as bedrails and hoists were used. Other health and safety risk assessments were in place for the management of people's mobility, infection control, Control of Substances Hazardous to Health [COSHH], catering and care delivery including risk of Percutaneous endoscopic gastrostomy [PEG] feeding [a means of feeding via a tube passed through a person's abdominal wall into their stomach], diabetes and pressure ulcers. Records showed that risk assessments were regularly reviewed.

We saw hoisting equipment being used appropriately and safely to transfer people to chairs in the lounges. Records showed hot water checks were monitored closely and action taken to reduce the risk of Legionella bacteria and scalding. Incidents and accidents were recorded and guidance had been provided to prevent re-occurrence where appropriate. Staff we spoke with knew about the procedures to be followed in the event of an emergency and changes in people's behaviour. Records showed that during a recent staff meeting staff had discussed the protocol regarding one-to-one monitoring of people and had been told to report to the nurse in charge if they observe any person using the service to be "withdrawn or if they expressed any self-harm wishes."

The provider employs a facilities manager who carried out a range of health and safety checks to do with the care home building and systems within the home to ensure they were maintained and serviced as required so people were safe. These included regular checks of people's wheelchairs and beds to make sure they were in good condition. Systems were also in place to ensure regular checks of fire safety, equipment including hoists used for lifting people, gas, water outlets including checks for the bacteria Legionella, hot water and electric systems took place. A recent health and safety check of the whole service had been carried out by an external service and records showed action had been taken in response to two recommendations.

There was clear fire guidance displayed in the home. The home had a fire risk assessment and each person

had a personal emergency evacuation plan. There was an emergency contingency plan in place and the contact details of people and services to be contacted in an emergency were displayed

The home was clean. Hand cleaning gels, soap and paper towels were available and staff had access to protective clothing including disposable gloves and aprons. Regular checks of the cleanliness of the bathroom facilities were carried out. Records showed that senior staff had been reminded to monitor infection control practices including hand hygiene and use of protective clothing. Staff were knowledgeable of infection control procedures. For example a member of staff told us about the various infection control measures that had been put into place in response to a person having an infection. These included educating staff about the condition and having guidance in place for staff to follow when providing the person with the care they required.

The housekeeping manager informed us that all housekeeping staff have completed infection control training. People told us they found the home to be clean and said staff observed hygienic practices. A person told us "They keep it very clean." People's relatives told us "We come at different times. It is always clean, including the windows," and "The premises are clean and comfortable." A waste paper bin in a bathroom did not have a cover, which could risk spread of infection. The registered manager told us they would make sure this waste bin would be replaced.

Good

Is the service effective?

Our findings

Relatives we spoke with all told us they felt happy with the care their family member was receiving. Comments from people's relatives about the service including staff; "They [staff] are very kind," "Food is good. My relative is eating well" and "The food is fantastic." People told us "The staff know about my condition. My condition has been stable. They are competent," and "They [staff] are nice."

Staff told us they had been provided with induction training and other appropriate training so they knew what was expected of them and had the skills they needed to carry out their role. Staff we spoke with told us their induction had been helpful in getting to know the organisation, the home, their role and responsibilities. A care worker told us they had spent time when they first started working in the home observing other staff supporting people with personal care, which they said helped them to get to know people's individual care needs and preferences. A senior care worker told us about their role of having new staff 'shadow' them. They told us about the importance of demonstrating good care practice to new staff. A care worker told us that during their induction they had "Learnt a lot," and had "Felt well supported and had time to learn." Records showed six staff had recently completed the new Care Certificate induction. The Care Certificate provides a set of standards that health and social care workers should adhere to in their work providing people with care and support.
We were informed by the human resource assistant that a trainer had been recruited and was due to commence work during the week following the inspection. Staff we spoke with informed us they received a range of relevant training. This training included safeguarding people, fire safety, moving and handling, health and safety awareness, food safety, infection control, and basic first aid. Other staff training appropriate for meeting the needs of people using the service included Mental Capacity Act 2005/Deprivation of Liberty Safeguards [DoLS], dementia awareness, dignity and respect, falls, data protection, mental health awareness and equality and diversity. A care worker told us they had recently completed a range of training and informed us they felt they had the skills to meet the needs of people using the service. Another care worker spoke highly of the recent dementia awareness and mental health training they had completed. They described the signs and symptoms of dementia and mental illness and told us that any changes in people's mental health would need to be reported to senior staff, the GP and placing authority. Records showed and staff told us that most care staff had obtained or were in the process of obtaining qualifications appropriate to the work they perform.

Care workers told us they felt well supported by the registered manager, unit managers, nurses and the rest of the staff team. They told us the registered manager was available for advice and support, and they were kept up to date with information about people's care needs. Nurses and care workers told us and records showed that staff received regular one to one supervision and occasional group supervision to monitor their performance, identify their learning and development needs, and discuss people's needs. Records showed some staff had received an appraisal of their performance. Records showed us that staff supervisions meetings and appraisals for the current year had been planned. The human resource assistant showed us the systems in place that monitored and checked these meetings were carried out.

People's health care needs were monitored and they had access to a range of health professionals

including; GPs, opticians, palliative care nurses, tissue viability nurses, intermediate nursing care support, and chiropodists to make sure they received effective healthcare and treatment. During the inspection two healthcare professionals visited the home to see people using the service. A person's relative told us "My relative has seen the doctor and we have discussed their care with the doctor." There was evidence of review of people's specific needs by speech and language therapists and dieticians, and protocols for enteral feeding regimens were in place. Records showed people had attended hospital appointments. We received positive feedback about the service from health and social care professionals.

The home is purpose built. People's care and treatment was carried out within four units, and each bedroom had ensuite bathroom facilities. Each unit had a number of communal areas which people could access. We saw there were signs on bathroom and toilet doors that indicated the purpose of the rooms which was supportive for people with dementia, and other people who might have difficulty with orientation. One unit which accommodated people living with dementia had a dementia friendly environment to support people's emotional well-being and independence. We saw that some people had personalised their bedrooms with personal possessions. There was a garden terrace area with some artificial grass but it lacked plants that could make the area more attractive. Management staff told us during our feedback session that they were going to put some plants in the garden.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Care workers and management knew about the requirements of MCA and DoLS. However, some care staff indicated they lacked an understanding of some aspects and purpose of MCA/DoLS. During the second day of the inspection the deputy manager told us she had responded to our feedback and had planned to carry out further MCA/DoLS training for care staff during the week following the inspection. Following the inspection the registered manager told us that two staff training sessions about MCA and DoLS for approximately 20 staff had taken place and further training was planned.

The registered manager was aware when authorisations needed to be made to restrict people's liberty. He told us people's needs were kept under review and an application for DoLS would be made if required. For example if a person's needs altered and there was a need to deprive the person of their liberty to receive care and treatment. Records showed that some people using the service were subject to a DoLS authorisation at the time of our visit. The registered manager told us that arrangements were in place to keep a check of the DoLS that were in place including their expiry dates. Following the inspection he told us that a system had been introduced to ensure DoLS were monitored monthly.

Staff we spoke with knew about people's rights to make decisions about their lives. Most staff recognised when a person lacked the capacity to make a specific decision people's families and others would be involved in making a decision in the person's best interests. A care worker told us "If a person cannot make a decision we support them with their family to make a decision in their best interests." Several people had swallowing problems because of medical condition. We saw multidisciplinary agreements were in place to document that specific feeding regimes for people were needed in their best interest. A care worker provided us with an example of when a decision about a person's care had been made in the person's best interest. People's relatives told us they had been involved decisions about people's care, and care plan records showed they had signed documentation to do with decisions about people's care and treatment.

The units had key pads to the lifts that accessed other areas of the service. We saw a person having to ask staff to access the lift for them as they wanted to visit the bistro area. They became agitated when they had to wait for staff to assist them. The registered manager said that some people following assessment had been provided with the key code to access the lifts and this person had probably forgotten the number. He told us that he would ensure everyone had a risk assessment about their ability to access the lifts safely and independently and would look at ways that made the key pad number easier to access by some people such as displaying it close to the lift.

People and/or their relatives had signed to consent to photographs being taken of people using the service and consent forms were in place regarding use of bed rails and indicated family involvement. A person's care plan included "Staff must gain consent from [Person] before any intervention." A care worker informed us that "I always ask people for their consent before providing them with care."

People's nutritional needs were assessed and monitored. Care plans showed people's weight was monitored and appropriate action had been taken in response to people losing weight which had included informing appropriate health professionals. Care workers knew they needed to report if a person had lost weight.

The chef knew about people's dietary needs and told us people's food preferences had been incorporated into the menu. The menu included meals that met people's cultural needs and vegetarian meal options were available at any time. A cook was employed specifically to prepare Asian meals for people. The chef was aware of people's individual dietary needs including those who due to swallowing difficulties needed a soft or pureed diet. Records showed appropriate action had been taken in response to staff being informed by a person's relative of the person's specific dietary need.

Staff we spoke with were aware of special diets needed by people with conditions such as diabetes and swallowing difficulties. We saw people being provided with a range of meals that met their preferences, cultural and dietary needs. Staff asked people what they wanted to eat and people were provided with the meal of their choice. Staff provided people with support with their meal when this was needed. Some people used adaptive drinking cups to enable them to drink independently. Jugs of water were placed in people's bedrooms and we saw staff encouraging people to drink fluids. A variety of drinks and refreshments were offered to people during the inspection. People at risk of malnutrition had their intake of food and dietary needs monitored.

The dining room tables had table cloths and flowers on each table. This ensured that there was a pleasant environment for people to have their meals. The menu was displayed in each unit in written format. On the first day of the inspection some units had menus in written and symbol format on the dining tables. We noted these did not correspond to the meals provided that day. However, on the second day of the inspection the menus were accurate. We discussed with the chef and the registered manager about displaying large photographs in the dining rooms so people who had difficulty reading and/or retaining information would more easily access information about the day's meals. The registered manager said he would take action to display menu photos.

We observed that staff were very supportive and active in assisting people with their meals during lunch time. However, we noticed that on one unit staff indicated they were not familiar with some of the meals and so were unable to describe them to people using the service. We also found the lunch experience for people on that unit disorganised. Following the inspection the registered manager told us that he had instructed kitchen staff to be a present in the dining rooms during meal times to support and direct staff with serving meals and to also obtain feedback from people about the meals. On the second day of the

inspection we observed breakfast on that unit and found the experience for people had improved. People we spoke with during breakfast told us they were satisfied with the meals and we saw positive engagement between staff and people using the service. A person told us they had chosen their breakfast, which they said they had enjoyed. We noticed people had to ask for condiments or had marmalade spread on their toast by staff. We discussed with the registered manager ways of promoting people's independence by providing condiments on the tables and developing further ways that encouraged people's self-reliance during mealtimes.

People were generally complimentary about the meals and told us that they had a choice of what to eat and drink. They told us "We have plenty of food," "I can have a cooked breakfast or boiled egg," "Food is ok, you can choose," "The food is sometimes nice, sometimes not so nice, but I don't go hungry," "Sometimes the food is good" and "We have choice, I chose porridge." However, one person said "The food is atrocious, it's tasteless, and they don't add salt." A person told us the "They give you fresh fruit if you ask; I go out with my [relative] and buy it." The chef told us that they offered fresh fruit but would look at ways of making it more available to people. A person's relative told us "My [relative] has not been eating; a senior carer has been wonderful giving extra time to support them with their food."

Good

Is the service caring?

Our findings

The atmosphere of the home was relaxed. During our visit we saw positive engagement between staff and people using the service. Staff spoke with people in a friendly and sensitive way. People were mostly complimentary about the staff and told us they treated them well, listened to them, and provided them with the care and support they needed. People told us "They communicate nicely and show respect for me. They do knock on the door before coming in," "The staff are nice. They do listen and talk to me," "Some carers are good, some not so good, about three quarters are good and a quarter not so good, they are probably still learning. Most of them are in a hurry when they wash you, others take their time, some chat," and "Sometimes when there are two carers, and they just talk to each other."

Relatives of people spoke in a positive manner about the care that staff provided. They told us "They [staff] are really kind, 99% of staff go out of their way, they are exceptional," "Regular staff are without doubt the best caring people I have seen," and "Everyone [staff] are handpicked and very good." Written compliments from people's relatives and others included; "We understand from [Person] that [Person] feels very much loved and respected and is appreciative of the care [Person] receives," "I am impressed about the care and the way residents are cared with dignity and respect", "Staff on 2nd floor are amazing, dedication is remarkable they are so committed to the job", "I'm very happy with [family member's] care. The carers are very good; they look after [Person] very well."

Staff we spoke with were knowledgeable about people's needs and positive about their experiences working at the home. They told us they enjoyed their job supporting and caring for people and worked well with other staff. A care worker told us "I love my job."

Staff confirmed they received detailed information about each person's progress during each shift so they understood each person's specific needs and were able to provide people with the care they required. Assessments of how people communicated had been carried out. These contained guidance to staff on how to communicate effectively with people. We saw a person's particular communication needs were detailed in their care plan and included 'I would like staff to introduce themselves to me by making eye contact, speaking slowly and keeping conversation as simple as possible and avoid jargon." We observed that staff had a positive rapport with people. Staff spoke in a gentle way with people and asked them how they were and what assistance they needed. We saw a member of staff sensitively encouraging a person to take part in an activity and fully understood the person's limited ability to participate in the task. A person's relative told us "They do treat my relative with respect. Some staff know how to communicate with my relative others do not. However, in the main things go fairly well."

We saw detailed information in people's care plans about their life history, preferred routines and interests. Most people had a key worker who supported them with their care and in aspects of their day to day lives. However, on one unit we found people did not have a key worker. The registered manager told us this was due to recent significant staff changes including a new unit manager recently being in post. The registered manager and the new unit manager told us they planned to ensure all the people on that unit would have the opportunity to have a key worker and would be fully involved in deciding who their key worker and key

nurse would be. Staff spoke of their key worker role. A care worker told us that they made sure their key person had the toiletries they needed and also regularly spoke with the person's family members about the person's needs. A unit manager stated that staff held regular one to one sessions with people so that they can express their views regarding the care provided. This was confirmed by some people we spoke with.

On one unit we saw pictures displayed of the staff team. The clinical lead told us she would look at displaying pictures in each unit of the staff on duty during each shift so people would be informed of this without having to ask.

Staff told us about supporting people's independence. These included decisions about what they wanted to do and services they wished to access. People had the choice of how and where they wanted to spend time during the day including periods of time in their bedroom, the bistro or other communal areas. People were provided with the equipment such as walking frames they needed to promote and maintain their freedom of movement. A person laid the dining tables in a unit. They told us they enjoyed carrying out that task as it was one they had carried out when living at home. The senior activities co-ordinator told us that people were supported to be involved in household activities if they wanted to. She told us a person using the service had managed the library [located in the home] until they had become unwell.

Staff understood people's right to privacy and we saw they treated people with dignity. Staff received training about respecting people's dignity. Staff we spoke with knew about the importance of respecting people's privacy and told us they made sure that the bathroom and bedroom doors were closed when supporting a person with their personal care needs. A care worker told us "Everyone need to be treated with respect, knock on the door, introduce yourself, let them [people using the service] know what you are doing, get their consent, involve them in what you are doing and respect their choice and wishes." The registered manager told us that he had plans for some staff to receive training to carry out the roles of 'Dignity Champions' to promote and ensure dignity for those using the service. We saw displayed information and guidance about supporting people's dignity.

Staff had a good understanding of confidentiality and knew not to speak about people other than to staff and others involved in the person's care and treatment. People's records were stored securely.

People were supported to maintain the relationships they wanted with friends, family and others important to them. Staff and visitors told us and records showed people had contact with their relatives. Relatives of people using the service told us they visited people during a range of different times of the day and evening and always felt welcome.

Staff understood that people's diversity was important and needed to be upheld and valued. Comments from staff describing equality and diversity included; "Respecting people's different cultures," "Try and understand people's choices and needs and respect them" and "Equality and diversity means respecting people's different needs, backgrounds, religions and culture." A care worker told us "I speak Hindi and a little Gujarati with residents." Care plans included information that showed people had been consulted about their spiritual and cultural needs. Staff told us that the service supported people to practice their faith. Representatives of various faiths regularly visited the home to support people with their spiritual needs. Records showed a person had attended a place of worship. People told us their birthdays and religious festivals were celebrated in the home. The chef informed us a cake was baked for people on their birthday.

Records showed that some staff had completed end of life training. The human resources assistant informed us end of life training was also included in the staff induction programme. Some people had end of life care plans. A person's care plan included information about their preference for not going to hospital if

they become unwell; that they have their dignity maintained and be seen by a GP. We found some end of life care plans well documented but some care plans we looked at stated that end of life wishes to be discussed with the family. Management staff told us people's end of life care plans would be reviewed and improvements made when required.

Good

Is the service responsive?

Our findings

People and their relatives informed us that staff listened to them and staff were responsive to their needs and views. They stated that people received care which they needed. One person said, "They have done a review of my care."

People's relatives told us that staff contacted them when people's needs changed and were positive about the activities. Relatives told us "Yes, they [staff] are responsive. I think it's very, very good, issues are addressed," "They [staff] keep me informed all the time. They understand [Person], " "I am involved," "We are amazed by the carers who appear to have excellent understanding of [Person's] needs and have a fantastic relationship with [Person]," and "The activities' workers are lovely and really good. There is a dementia awareness event they are doing that I will go to."

Records showed that people, their relatives [if applicable] and others including healthcare professionals had been asked questions about people's needs before the person moved into the home. People's initial assessments carried out by the service included information about a range of each person's needs including; dependency, medical history, health, social, care, mobility, medical, religious and communication needs.

We found people's care plans had been reviewed and written in a new format which was more 'person centred' than the previous care plans. The care plans took account of each person's individual needs, abilities, interests and preferences. People's care plans had been developed from the assessment of their needs, and included information about each person's individual preferences. For example in a person's care plan it was written "[Person] would like their door open at all times and would like the lights to be dimmed in [Person's] room at night." People's care plans were accessible to all care and nursing staff. Staff told us they read and followed people's care plans.

People's complex nursing needs were identified and care plans in place for tracheostomy, laryngectomy and Percutaneous endoscopic gastrostomy [PEG, feeding via a tube into the stomach via the abdominal wall] feeding care. For example a tracheostomy care plan included guidance for staff to minimise the risk of infection, details about the person's respiration status that needed to be maintained including their oxygen level needing to be above 90%. This care plan also included guidance about minimising the risk of the person choking by positioning the person in a particular way. We saw care plans for people who had Parkinson's disease, epilepsy, motor neurone disease, multiple brain tumour and diabetes. However, one person's diabetes care plan mentioned that staff should observe for signs of hyperglycaemia [high blood sugar] and hypoglycaemia [low blood sugar]. It did not include details about the specific signs of these conditions. The clinical lead member of staff told us this guidance would be put in place promptly and other similar care plans reviewed.

Systems were in place for effective responsive wound management and care. For example records showed that a person who was admitted with a pressure ulcer received appropriate care and the wound healed within a few days. Appropriate equipment including specialist mattresses were used to relieve pressure on

pressure areas. Pressure area risk assessments were in place, up to date and included body maps and regular photographs of the condition wounds and pressure ulcers if applicable.

There was evidence that care plans were reviewed regularly, and were updated when people's needs changed. Some care plans clearly indicated involvement of service users and relatives and included comments and contribution to the care plan made by relatives. People's relatives told us they had been involved in in people's care plans and their review and were kept informed about any changes in their relative's needs. Information from professionals involved in people's care had been recorded. Records showed that nurses and management staff had been responsive to people's individual health needs and had contacted a GP when people had a medical need. A record from a person's relative informed us that when a person was unwell a nurse "Took everything on board and acted very confidently and professionally and managed to get 'out of hours' to visit thus avoided hospital admission."

Records showed people were offered regular drinks when they were at risk of dehydration and repositioned regularly when they had a risk of pressure ulcers. However, fluid monitoring records we looked at did not include records of people's fluid output. The registered manager told us this would be addressed promptly. Regular checks of each person were carried out during the night and drinks were provided. One relative was told us they had been concerned that his relative's continence pads weren't changed as often as they thought they should be and told us "My only problem is that they could change her more frequently."

Staff we spoke with told us they discussed each person's needs and progress during each shift so they knew how to provide people with the care they needed. We observed this when present during a staff 'handover' meeting. A care worker told us that during the handover meetings "We share information, we are told about changes. We work well as a team." Staff knew they needed to report to the GP when people's needs such as mobility needs, weight or skin condition changed.

Activities co-ordinators were employed to support people's involvement in activities during weekdays and weekends. Records showed there was a comprehensive assessment of each person's activity needs and preferences and each person had a social and leisure care plan. The activity timetable was displayed in the units. Activities included bingo, coffee mornings, group baking and cooking, discussions and reminiscence, arts and crafts, ball and board games and pet therapy. During our inspection we saw people had the opportunity to participate in a range of activities, these included group and one-to-one activities such as ball games, watching a film in the service's cinema, reading newspapers with people and knitting. People also spent time using their personal computers, taking part in a library activity and a coffee morning. Records including photographs showed people took part in a wide range of activities. We were provided with an example of a person who when first admitted chose to stay on their bed most of the time but through staff support and encouragement was now engaging in activities including group activities and attended a church service outside the home. A relative told us that the activities were "Good and interesting."

We saw the senior activities co-ordinator go round each unit speaking with each person using the service and encouraging them to take part in activities of their choice. Staff also respected people's decision when they chose not to take part in an activity, and offered them alternative occupation. The senior activities co-ordinator told us that it was an on-going challenge motivating some people to join in activities and there were people who preferred spending time on their own or talking with staff. We discussed with staff the possibility of seeking volunteers to spend one-to one time talking with people. We saw the senior activities co-ordinator spend significant time speaking with a person who had refused a range of activities. There was positive engagement between them and the person agreed to do some gentle exercises. The home has pet

birds. A person using the service was observed smiling and talking to staff whilst having a pet parrot perched on their shoulder. People had access to a hairdresser. We were told some people visited the local supermarket with family and /or staff. Some people told us they would like outings to take place. The activities co-ordinator told us she was in the process of arranging a trip for people to visit a local country area. The registered manager told us the purchase of a vehicle to take people out was being considered.

A suggestion box was accessible to people in each unit as a way to provide feedback about the service. There was also a complaints book where people using the service and others could write comments, complaints and compliments. People's relatives told us they knew how to make a complaint, would not hesitate to raise any issues or concerns they had about the service and were confident they would be taken seriously by the registered manager and/or other staff and addressed appropriately. A relative stated that when they complained it was promptly responded to. Staff knew they needed to report all complaints to the registered manager and/or other senior staff. A care worker told us "Small complaints are important they can turn into big things. They need to be nipped in the bud, documented and reported." The registered manager told us he had an 'open door' policy.

Records showed a number of compliments about the service had been made. These included compliment from relatives including "Please express my thanks, I was very impressed with the care and compassion showed by all the carers," and "Thank you for taking on our concern and for being so professional in your approach. We are very pleased about the meeting today."

Good

Is the service well-led?

Our findings

People and their relatives informed us that they had confidence in the management in the home and spoke well of the registered manager. They told us he was approachable and listened to them. People told us: "It's 100% -I can't fault them [staff]. I can't find a better place. The carers are highly professional," "It's OK," "It's been marvellous so far," "I think it's very good. You can't fault it. It's the nearest to home you can get. I think they do very well" "On the whole it's a pretty good place," and "The home is well managed. I can talk to the manager if there are problems."

Comments from relatives included; "[The registered manager] is a most lovely man. He is a genuine really nice man," "[The registered manager] has done amazingly. He has made good changes. Things have improved," "I have [the registered manager's] mobile phone number I know I can contact him anytime." Written compliments about the service included; "The registered manager] and [another member of staff] are highly professional, efficient nurse managers leading their team brilliantly," "Victoria Care Centre is one of the best," and "I am impressed about the care home and the way residents are cared for."

The management structure in the home provided clear lines of responsibility and accountability. The registered manager managed the home with support from the directors, a deputy manager, clinical lead, four unit managers, nurses, administration and other staff. There is an on-call procedure in place so staff could obtain advice and support from senior staff at any time. During our visit the registered manager provided us with all the information we requested and was receptive to our feedback. A unit manager told us that weekly meetings with the registered manager and other senior staff took place during which a range of areas to do with the service were discussed.

Records showed the home worked with partners such as health and social care professionals to provide people with the service they required. Health care professionals visited people during the inspection. Records including notifications received by us demonstrated the registered manager kept the local authority commissioning and the safeguarding teams informed of any incidents, accidents, complaints and other significant issues to do with the service. During the last few months the registered manager had been working closely with the host local authority and clinical commissioning group to develop and improve areas of the service. The registered manager had also kept us informed of any incidents and accidents and supplied us regular updates of any action that has been taken to improve the service provided to people.

We saw the minutes of staff meetings and noted that issues related to the care of people, conduct of staff and management of the service had been discussed. Staff said they could also discuss and raise issues to do with the care of people and other aspects of the service during those meetings. Staff we spoke with told us they felt listened to and were confident that any issues they raised would be appropriately addressed. Records showed that during a recent staff meeting staff had been asked if they had any ideas about how the service could be improved. A care worker told us "The manager is very nice and approachable." Records showed a range of practice issues including safeguarding people, consent, respect, communication, fire safety, falls, monitoring people, reading care plans and record keeping had been discussed with staff during supervision and team meetings.

People had the opportunity to participate in regular resident and relatives meetings to provide feedback about the service. A relative told us "I have reported things and they [staff] have addressed them." We saw from minutes of relatives and residents meetings, which included feedback from people which had been addressed by the service. We were informed that people and relatives of people using the service had the opportunity to complete feedback surveys and were told a survey was currently in the process of being completed by people. Records of feedback surveys showed people had provided positive feedback about the activities and issues raised had been addressed. A survey about people's views on the food had been carried out and action had been taken to make improvements. For example in response to two people's feedback, an adapted individual menu incorporating each person's preferences had been developed for them.

The clinical lead told us she had planned to develop clinical policies that related to the service. We saw that currently nursing staff had access to the clinical policies of a renowned organisation. Every person's care plan had recently been reviewed and improved. A care worker told us "They are better now they are in one file and easier to read, so we know the care people need." Following the inspection the registered manager told us the task of developing the clinical policies was in progress and would be completed by middle June 2016.

There were quality assurance systems to monitor the service and to make improvements when required. Records showed checks of a range of areas to do with the service were carried out by the registered manager, unit managers, nurses and maintenance person. These included hourly checks of some people's care and daily checks of people's care records, bedrails, condition of mattresses, fluid and nutrition monitoring records, staffing levels, cleanliness of the environment, medicines and checks whether call bells were in reach of people using the service. Regular audits of equipment including wheelchairs, walking frames, shower chairs, people's care plans, medicines, wounds, stoma and tracheostomy monitoring, infection control, accidents, window restrictors, extractor fans, activities, temperature checks of fridges and freezers were also carried out by staff.

Monthly room checks were carried out and records showed action had been taken when faults were found or when a room required decorating. The service had a Health and Safety committee which included a representative from each unit who met regularly to discuss issues and take action to make improvements to do with health and safety of the service. Records showed action had been taken to address some health and safety matters. Action included displaying a fire safety notice in each unit and staff to watch over each stair exit when the fire alarm is activated to minimise the risk of people accessing and falling down the stairs during fire alarm tests. Records showed staff had received training about this task.

The registered manager promptly responded to our feedback from the inspection and told us about the action staff had taken in response to our feedback. He informed us there were plans to put in place more comprehensive checks in a range of areas including; pressure ulcer checks, infection control, medicines and incidents which would incorporate checks carried out on each unit. The registered manager told us that these checks would include looking at common features and causes of incidents for example and then make improvements to the service to minimise the risk of reoccurrence. Following the inspection the registered manager told us that all the units now used the same comprehensive improved audit tools to ensure consistency of quality assurance auditing throughout the service. He told us these were being monitored closely by the management team.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines were not always being managed in a proper and safe way. Regulation 12 (2) (g).