HC-One Limited

Victoria Manor

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

The last inspection took place on 1 September 2015 when this service was rated as 'good'. This inspection took place on 8 November 2017 and was unannounced. We found the service continued to be good in four of the key questions. Some improvements were identified in relation to the key question of Safe. The provider had recognised there had been a decline in some standards at the home following our last inspection and had acted upon these to ensure the home continually improved.

Victoria Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home provides personal care, including for those living with dementia, and accommodates up to 30 people across two floors. There were 26 people living in the home at the time of our inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission 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 2008 and associated Regulations about how the service is run. The registered manager had been in post since June 2017 and was registered with us in August 2017.

People told us they felt safe living at Victoria Manor and there were systems and processes to protect people from the risk of harm. Staff knew how to manage risks associated with people's care and to report any concerns to the registered manager. There were enough staff available to support people's needs but we received varying views of the effectiveness of staff, partly due to the number of agency staff used in the home.

There was a procedure to manage people's medicines but this was not consistently followed to ensure medicines were managed safely.

The environment had been adapted to take into account people's physical needs and to support people's dementia. There was a process to undertake safety checks of the environment and equipment although we identified some hot water pipework that had not been covered to minimise the risk of burns to people. The home was clean and staff understood what was expected of them to maintain good infection control practice within the home.

Staff received training in areas considered essential to meet people's needs safely and consistently, and there were enough suitably trained staff to meet people's personal care needs.
New staff received an induction to the home that helped them to understand the individual needs of the people who lived there.

Staff had a working knowledge of the Mental Capacity Act and understood the need to ensure people

consented to care before this was provided. Where restrictions on people's liberty had been identified, Deprivation of Liberty Safeguard (DoLS) applications had been made to the local authority.

Staff were caring and considerate in their approach to people and did not rush people when supporting them. They understood the need to respect people's privacy and dignity and to give people choices about how they spent their day. People had access to some social activities of their choosing and were also able to participate in group activities. We saw positive engagement between people and staff. The activity co-ordinator (referred to as wellbeing co-ordinator) post was vacant at the time of our visit.

People were provided with a choice of meals and these looked hot and appetising. Snacks and drinks were provided throughout the day to maintain people's nutritional needs.

People accessed healthcare professionals when needed. A GP visited the home each week and people were also supported to attend regular health checks to maintain their physical and mental health.

Staff were positive about working at the home and felt supported by the management team. There were quality monitoring systems and processes to ensure the home ran effectively. People and staff had opportunities to share their opinions and views of the home to help drive improvement. A programme of audit checks ensured the service worked in accordance with the provider's policies and procedures.

There was a complaints procedure on display to inform people and visitors on how to raise a complaint. Records were kept of complaints received and we saw action had been taken to respond to them.

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

The service was not consistently safe.

Staff understood how to keep people safe and there were systems to identify and minimise risks related to the care people received. There were enough suitably experienced staff to meet people's care needs but people told us they had mixed experiences of care dependent on the staff that supported them. Sometimes people were supported by agency staff who didn't know their needs well. The home was clean and staff understood how to maintain good infection control. There were some uncovered hot pipes in the home that presented a burn risk although these were protected following our visit. A safe procedure for managing people's medicines was not consistently followed.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Good

The service remains Good.

Victoria Manor

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.

This inspection took place on 8 November 2017 and was unannounced. The inspection team consisted of two inspectors.

We reviewed the information we held about the service including contact made by members of the public (this was both before and after our inspection visit). We looked at information received from agencies involved in people's care including the local authority commissioners who funded care for some people at the home. They confirmed information the service had shared with us about reportable incidents at the home. We looked at the Healthwatch report which had been completed following their visit to the home on 31 October 2017. This was a positive visit. We analysed information on statutory notifications received from the provider. A statutory notification is information about important events which the provider is required to send us by law. These can include safeguarding referrals, notifications of deaths, accidents and serious injuries. We considered this information when planning our inspection of the home.

We used information the provider sent us in the Provider Information Return (PIR). This is information we require the providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

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 could not talk with us.

We looked at three care plans and viewed other care documentation such as people's weight charts, medicine records, food and fluid records. We looked at accidents and incident records, health and safety records, the complaints file, safeguarding referral records and quality monitoring checks carried out by the provider. We attended a handover meeting with staff at the beginning of the morning shift with both day and night staff.

We spoke with three people who were able to speak with us and observed how people were cared for on each floor. We spoke with three visitors to the home including a healthcare professional. We spoke with the registered manager, four care staff, the housekeeper, the maintenance person, the cook and the area director who was visiting the home.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we found people received good safe care. At this inspection we found some improvements were needed to ensure people received consistent safe care and therefore rated the key question of 'Safe' as Requires Improvement.

People told us they felt safe living at Victoria Manor because they felt safe in their environment and with the staff that supported them. One person told us, "Yes I am feeling safe, it's the whole place (that makes them feel safe), it's nice, I am lucky." Staff had completed training on how to keep people safe from harm and knew the signs of potential abuse. Staff knew to report any concerns they had to the registered manager to keep people safe. The registered manager was aware of their responsibility to report any potential abuse to us and the local authority. Our records confirmed safeguarding referrals had been made as appropriate. This was so that we could be assured the required action had been taken to manage any risks to people's safety, health and wellbeing.

Corridors on both floors were well lit and wide enough for walking aids and wheelchairs. There were systems for staff to report maintenance issues and to ensure they were dealt with promptly so the premises remained safe. However, we found there were uncovered hot pipes in some areas of the home that could place people at risk if they should fall against them. We reported this to the registered manager and they confirmed to us following our visit that action had been taken for them to be covered.

People and visitors felt staffing arrangements were usually sufficient. A relative told us they felt their family member was safe "most of the time" but there were sometimes not enough staff available at weekends. They explained sometimes if agency staff were on duty this impacted on people because they were less knowledgeable of people's needs and how to meet them. Staff shared this view, one staff member told us they sometimes found it difficult to complete their duties as they should. They said there was meant to be someone in the communal areas at all times so that people at risk of falling could be kept safe and anyone needing support had a staff member available to assist them. However, they told us this could be difficult when agency staff were on duty. This was in part due to time they needed to spend with agency staff to support them as this took them additional time. They told us, "We do pretty well to ensure people's needs are met to a high standard. When all the staff are permanent, everything runs so much smoother."

The registered manager and provider's area director told us people's dependency needs were assessed to determine the number of staff required at the home. They told us staffing levels were adjusted accordingly if people's needs increased and described how this had been the case recently when a person's health deteriorated so they had needed to increase support until they were admitted to hospital.

Duty rotas showed there were mostly six care staff as planned (including the deputy manager) on duty during the day. However, there had been a recent Sunday where only four care staff were shown to be on duty to support people which meant people's needs may not have been supported sufficiently. We also noted there were codes used on the duty rotas that were not clearly defined, for example "Tr". We could not determine from the duty rotas if these staff were working as part of the shift or not. However, where there

were gaps in staff availability such as when there was staff sickness, these shifts had been covered by agency staff which demonstrated the registered manager had attempted to cover the shifts.

Despite duty rotas not being clear, we saw during the day there were sufficient staff to provide personal care to people without them feeling rushed. In addition to care staff, there were ancillary staff to support the effective running of the home. This included laundry, domestic and kitchen staff. There was an ongoing recruitment programme at the home for new staff.

Pre-employment checks were carried out before new staff worked at the home. This included a Disclosure and Barring Service (DBS) check and written references. The DBS assists employers by checking people's backgrounds for any criminal convictions to prevent unsuitable people from working with vulnerable people. Staff confirmed these checks were completed before they started work at the home. Staff files we checked showed background checks were completed before they started work but one file did not contain two written references. The registered manager advised this had been located following our inspection visit.

Risks associated with people's care such as risks related to skin care, falls and nutrition had been assessed to determine what support people required to keep them safe. Where risks had been identified, care plans had been developed to manage those risks. For example, we saw one person was at risk of skin damage because they sat for long periods. Arrangements had been made for the person to see the doctor and this resulted in a district nurse visiting the person regularly to check their skin and provide any treatment necessary. Staff were required to apply prescribed creams to the person's skin regularly to prevent further skin breakdown. Staff recorded the application of creams on records kept in the person's room to confirm they had been applied as prescribed.

There was a risk that people did not always receive care and support as planned. We noted when we looked at supplementary records these had not always been completed to demonstrate care was consistently provided. For example, one person's personal care record showed long gaps between personal care support although staff told us all people's personal care had been provided. From the appearance of the person, it looked to have been provided. The person had not been eating or drinking well so supplements had been prescribed by the GP to help provide them with more calories to support their health. However, the records showed the person was not drinking regularly to maintain their health and prevent the risk of infections. Staff said they felt people's needs were sufficiently met. One staff member told us, "The care is very good."

We discussed the issue around supplementary records with the provider and registered manager who assured us that they had already identified this issue and actions were being taken to address. Notes of a staff meeting on 6 November 2017 demonstrated that the registered manager raised areas needing improvement with staff. For example, medicine management and the completion of supplementary records, so that the necessary action could be taken to improve these and ensure people's needs were met safely. The area director told us the company would be introducing hand held devices for staff to use to record all staff interventions including the provision of any food and drinks. This new system would therefore help to ensure records were updated at the time of care delivery.

Equipment was available around the home to manage risks associated with people's care, for example, some people sat on pressure relief cushions to help prevent the risk of them developing sore skin. People had walking frames and wheelchairs to support them move around the home. We also saw staff walked alongside people to make sure they reached their destination safely. Staff told us they were updated on any changes to people's health, and potential risks, at 'handover meetings'. Handover meetings took place at the beginning of each shift, staff finishing their shift handed over information about people to staff starting

their shift. This helped to make sure anyone who may be at risk of harm or ill-health were monitored closely to minimise these risks.

People told us they received their medicines as prescribed. Care staff told us they completed training before they were able to administer medicines and checks were made to make sure they administered medicines safely. When we checked medicine records, we found these were not always managed effectively. One person was to have a cream applied twice a day but the records did not show this happened. The person's skin care plan stated this person was prone to dry and sore skin, it was therefore important this cream was applied. Another person was to have a pain relief patch applied to their skin but the location of this had not been documented. This was important so that staff would know where to apply any further patches as these should be rotated around the body to prevent any possible side effects. The staff member who applied the patch took action to record the location of the patch during our visit.

We could not be confident that the correct codes were always used on the medicine administration records (MAR's) so that it was clear how the medicine had been managed and when medical advice may need to be sought. For example, on one person's records the code "F" had been recorded to show the person was sleeping but we established the person had refused their medicines so the code "A" should have been used. Another MAR showed there was one day when the person did not have their medicines. This included a medicine prescribed 30 minutes before food. The person had been asleep at the time the medicines were being administered but when we checked the handover records, there was no instruction for staff to administer the medicine on the person waking. One person had been prescribed a pain relief medicine to be given "PRN" (when required). However, there was no protocol in place to show how staff would know when to give this. This was addressed on the day of our inspection visit. The provider had told us of plans already in place to improve records and monitoring of people's care including medicine checks.

Medicines were safely stored in a locked medicine trolley. Checks of medicines were undertaken by the registered manager.

Accidents and incidents in the home were recorded on a central system which the provider and registered manager were able to view and check for trends or patterns. We saw 'incident investigation reports' were completed when people had accidents or injuries so that lessons could be learned to minimise the risk of them happening again. For example, where one person had fallen and sustained an injury, a risk assessment was completed. A sensor mat had been put where the person was at risk of falling (that set of an alarm if touched to alert staff to assist) and two hourly night checks were to be completed. The Provider Information Return (PIR) told us following a recent audit of falls that an action area was for all equipment used by people to be checked. This action had also been implemented due to an incident at the home where one of the sensor mats had not worked. A daily check list had been implemented to make sure equipment continued to be in good working order.

The provider had arrangements for staff to manage any emergencies at the home. This included each person having a personal emergency evacuation plan (PEEP) so staff and the emergency services would know what support each person would need if they had to evacuate the home. We had been told about an incident at the home in June 2017 whereby a person who was not safe to leave the home independently had exited the building through the fire exit. Although the person was found, staff had not been clear on how to turn the alarm off so as not to cause any raised anxiety to those living at the home. Since this time, a new door had been fitted which was more secure and a meeting had taken place with all staff so they were fully aware of the door alarm system. This demonstrated lessons had been learned and actions taken to help prevent this happening again.

The maintenance person told us they talked staff through the fire evacuation procedure when they first started work at the home. Staff were required to sign a document to confirm they knew and understood the fire procedure. The maintenance person told us a minimum of two fire drills were carried out per year for all staff and they regularly checked the PEEPs in the evacuation file to make sure they were up to date.

The PIR told us the provider had effective systems to monitor and manage infection control within the home. However, there had been a concern raised by a relative at the home in relation to the management of their family member's laundry. They had made specific requests in regards to the storing of soiled laundry, when in the person's room. They had found these requests had not been followed. This had meant the person had been placed at risk of infection because they had frequently come into contact with the soiled laundry. We noted following our inspection, action had been taken by the provider to make sure the requests were met.

Staff had completed infection control and prevention training and an infection control audit was completed quarterly by the registered manager. We saw examples where staff put their infection control learning into practice such as when a staff member noticed a problem with one person's finger. The staff member immediately put gloves on and suggested to the person they go to their room so they could attend to it. We saw staff wearing gloves and aprons during our visit to maintain good infection control practice.

Good

Is the service effective?

Our findings

At this inspection we found staff continued to have the same level of training and support to enable them to meet people's needs effectively as we had found at our previous inspection. People's choices and dietary needs continued to be considered and supported where possible. The rating continues to be Good.

People's needs were assessed when they came to live at Victoria Manor so their care could be planned based on their needs, wishes and choices. People's care plans contained information about their physical, mental and social care needs and contained instructions for staff on how they needed to support people to ensure these needs were met.

We saw consideration had been given to adapting the premises to support people's needs, particularly for people who lived with dementia. For example, there were different coloured doors and toilet seats to help people identify these easily. There were items of interest to look at and touch including pictures, photographs and butterflies on the walls in corridors and lounges. Corridors had handrails to support people who may have difficulty walking without support.

Staff we spoke with knew about people's needs and choices. For example, they knew one person liked to colour pictures in a book. They knew the person's family had bought them some new colouring pens and provided them to the person for them to use, we saw the person smiling and enjoying this activity. Staff knew about people's favourite foods. For example, when staff were offering people biscuits, one person said "Have you two of my favourites?" Staff knew these were custard creams and offered them to the person.

Staff told us they completed regular training and their required training was up-to-date. The registered manager confirmed this. The registered manager told us staff competence was monitored following training by 'ten minute' meetings. They told us these meetings were used to ensure staff had fully understood what they had learnt and the importance of why they did things a certain way. For example, they explained to staff why the completion of food and fluid charts was important and the consequences for the person (such as malnutrition) if an accurate record was not kept. They told us these meetings were also used if it was felt staff needed their knowledge refreshed in any specific area.

New staff completed an induction when they started working at the home and staff told us they found this was sufficient for their work. A key part of the induction for new staff was completion of training based on the Care Certificate which was introduced in April 2015. The Care Certificate sets the standard for the fundamental skills, knowledge, values and behaviours expected from staff within a care environment. One staff member told us, "I did moving and handling (people), I did quite a bit of training until I could go on the floor, I shadowed (worked alongside) other staff." Another staff member told us they had not been "allowed to lift or anything" until they had completed the required training. They also said they had worked alongside more experienced staff before working independently. This was to ensure they felt confident and competent in their skills and abilities to support people safely.

The Provider Information Return (PIR) told us that most of the staff at the home had completed training to

support people with dementia. This also told us staff were supported to carry out their roles through effective communication, appraisals and supervisions. Staff confirmed this. Staff told us they had regular supervision meetings with their manager where they could discuss their personal development and any training requirements.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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.

Staff knew how to approach people so they could communicate with them effectively. They understood the importance of gaining people's consent. One staff member told us, "I say, 'would you like to have a wash or get your night clothes on'." Another told us, "Don't automatically assume what is right for them" and went on to say they were required to act in people's best interest and give people choices where possible.

We saw staff sought consent from people and waited for people to respond before delivering care. For example, people were invited to go to their rooms to be assisted with personal care and to see the GP who was visiting the home. We also saw people were asked if they wanted to move to their rooms when they expressed they were not happy with the noise levels in the lounge.

Where people refused personal care, staff told us they would find ways to help ensure this was addressed. For example, they told us about one person who regularly refused personal care but would become anxious if they were asked too many times. Staff ensured this was reported at handover meetings at the beginning of each shift. They said they addressed this by using the opportunity when the person needed to use the bathroom to wash them and change them into clean clothes so the person didn't become anxious.

The registered manager was aware of the requirement to seek authorisations from the local authority for those people where restrictions were placed on their care, and DoLS authorisations had been made. Where some of these authorisations were due to expire, applications had been made as appropriate for these decisions to be reviewed. Staff had completed training in DoLS and had some understanding of this. One staff member told us, "Yes I have done training. That's for people who lack capacity."

At lunch time people were assisted to the dining rooms based on each floor to have their meals. Meal times were not rushed and were a relaxed experience for people. People said they liked the food. One person told us, "The food is very good, you get a choice." Another said, "Food wise it is fine." We saw most people were offered choices and the meals looked hot and appetising. We saw the cook ask a staff member to choose a meal for one person and the cook asked what meal they might want. The staff member said the person would like either of two available but did not take two plates of food to the person to enable them to visually choose. When we questioned them about this they said this was something they normally did. One person was asked if they wanted banana mousse or yoghurt for pudding. They selected the yoghurt, and were then asked what flavour of yoghurt they would like. After eating it, they were asked if they had enjoyed it and

stated "Yes, very much, thank you" which showed that people's likes and preferences were considered and met.

We noticed that one person had not eaten much of their lunch and they told us it was "Not quite what they wanted" but went on to say they had eaten, "A good breakfast" and had eaten all they wanted from the plate. They told us they had been given a choice and would see what it was for pudding and we saw them eat the pudding.

We saw people were provided with adapted cutlery and plates to assist them to eat and drink. Risk assessments on people's care files confirmed how people needed to be supported at mealtimes.

We asked the cook how they accommodated people's differing dietary needs. They told us they worked to the provider's menu but were aware of peoples' differing needs such as those on fork mashable diets. They told us there was one person who liked tomato sauce sandwiches rather than a meal so this was provided at their request. We asked about people's cultural dietary needs and were told all people in the home were happy with the menu provided. The cook said they spoke with people regularly to obtain their views of the food and would check at lunch time what they liked and didn't like and would ask people if they were enjoying their meal. The cook told us high calorie chocolate bars were provided for those people on a fortified diet (where extra calories are added to food) and they were aware of people's likes and dislikes.

Snacks and drinks were offered regularly through the day from a tea trolley that went around the home. Drinks were placed on small side tables so people could easily reach them. The cook said that people could have a drink at any time if they wished and stated food was left in the fridge in the evening so that care staff could prepare snacks for those people that wanted them.

The registered manager had noted following an audit for July and August when the weather was hot there had been an increase of infections in the home. In response, they checked the amount of fluids people had received and had recognised this could be a contributing factor. Meetings were held with staff about the importance of increased fluids to help manage this risk. This demonstrated that risks were identified and acted upon to maintain good infection control management in the home.

Food and fluid charts were completed by staff to monitor how much people ate and drank to ensure this was sufficient to maintain their health. When we looked at one person's charts, they showed they regularly refused meals and drinks. However, it was clear staff regularly offered them drinks to prevent any risks of dehydration. We noted on the day of our visit the person's food charts did not show whether the food was fortified in accordance with instructions. However, we saw the person had been provided with an energy bar and biscuits in addition to their breakfast which they had eaten. This showed additional calories had been provided to help maintain the person's health.

Health checks were organised when people needed them to maintain their physical and mental health. These included visits from district nurses, the GP and optician. One person's care records showed the GP had been called when staff were concerned about the person's weight loss. This had resulted in food supplements being prescribed to manage this.

We spoke with a healthcare professional who attended the home during our visit. They were complimentary of the service and stated that staff followed their instructions to effectively maintain people's health.

Good

Is the service caring?

Our findings

At this inspection we found people continued to be positive about their experiences of the home and staff. People had developed relationships with staff and the rating continues to be good.

People and visitors we spoke with were positive about the staff and the care provided at the home. One person told us, "They (staff) are nice people to be honest." A relative told us staff were "kind" and commented how the staff tried to encourage their relative to take part in activities in the home so they did not become socially isolated. Another relative told us they were made to feel welcome at the home and had a "good rapport" with the staff.

During our visit we saw positive interactions between staff and the people who lived there. Staff were kind in their approach, and engaged people in conversations of interest to them such as speaking about family members. Staff spoke with people calmly when they became anxious. For example, when one person became unsettled due to the noise levels in the first floor lounge, a staff member spent time reassuring them to help prevent their anxiety levels from increasing. When a person became upset in the ground floor lounge, a staff member said kindly, "Don't get upset, where's that nice smile gone." We saw a staff member asked one person if they could reposition them in their chair because they looked uncomfortable.

Staff acknowledged people as they moved around the home and took time to engage with people as they carried out their duties. People told us they felt involved in decisions about their care and we saw throughout the day they made choices such as where they sat, what they ate and what they wanted to do. We saw some people chose to eat in the communal areas at lunchtime as opposed to the dining room.

The Provider Information Return (PIR) told us that regular care reviews took place with people and their family members. At one care review, a person had expressed that they wanted to go for a walk in the garden after lunchtime. We saw that this happened.

We asked staff how they developed caring relationships with people. One staff member told us, "We talk about their past and what they did when they were younger, we get the photos out. There is information on their care plans about their likes and dislikes." They went on to tell us how one person only liked blackcurrant juice and preferred a yoghurt to a pudding and did not like spicy foods. They knew the person's favourite sweets and told us they sometimes provided sweets to people or a snack box with chocolate and fruit in it.

The registered manager told us how a visiting health professional had left positive comments about the staff and saw these comments included, "It's very nice to see staff in a care home who actually do care about residents and their families."

Staff understood the importance of promoting and maintaining people's privacy and dignity. People appeared clean and well-presented and a member of staff commented how it was important for people to be dressed "nicely" and given a choice of what to wear. The staff member told us "[Person] likes to have

make-up 'rouge' in the morning and nice hair, some have a bottle of perfume they like, they ask me to put it on."

The PIR told us, "Dignity and kindness is at the centre of everything we do ….residents' wishes in terms of privacy and dignity are fully reflected in their care plans. We also respect residents with always protecting their personal space; knocking on a door before going in, respecting meal times and providing protective mealtimes." We saw staff knocked doors before entering people's rooms and during mealtime's people sat and talked with one another so it was a positive sociable time of the day for them.

Good

Is the service responsive?

Our findings

At the last inspection this key question was rated 'requires improvement'. We found at this inspection the necessary improvements had been made to respond to people's needs so rated this key question as Good.

People said they were involved in decisions about their care and felt staff were responsive to their needs. One person told us, "It is very good, the carers wash and dress you in the morning, you get your meals and any problems, they are here to help you. The staff are great, they really look after you well." A relative told us, "The majority of the time the care is good."

People's care records confirmed their needs were assessed prior to them coming to the home to ensure these could be met effectively. People's needs were detailed in care plans with instructions for staff to follow to ensure they were met. For example, one person was at risk of falling if they were to attempt to stand. Staff were therefore instructed to ensure when the person needed to move, to use a hoist. When we visited the person's room, the bed had been lowered and a pressure mat and 'crash' mat was on the floor. This was so if they fell from their bed onto the 'crash' mat, their fall would be cushioned to help prevent any serious injury. Staff would be also be alerted to their fall by the pressure mat which would set of an alarm so staff would know to go to the assistance of the person. The person's care review records showed the person had commented to staff "You're good" suggesting they were satisfied with the care they received. We saw the doctor regularly visited the person to check on their health.

Care plans detailed people's preferences in regards to their care and staff knew how to support people in ways they preferred. Staff told us because they knew people well, they knew their routines and how often they would need support with personal care. They told us people could have showers and baths when they wanted but advised most people needed encouragement to have a shower or bath which they provided. People's interests were detailed in care plans. In one person's care plan it stated the person preferred their own company, didn't like to be prompted too much and didn't like "busy" environments. During our visit, we saw staff respected this person's wishes.

We saw that both male and female staff were employed at the home to support people's preferences for personal care support. People's care plans also indicated their preferences for male or female support.

We asked the registered manager and staff about how they considered equality and diversity when assessing people's needs to make sure these needs were met. We noted that people's sexuality was not always referred to in care documentation and there was no information in pre-admission information to support staff in beginning to ask questions about this. For example, there were no questions about people's life partnerships, there was only a question asking if the person had been married. We noted when we looked at the publicity information for the home, the information including photos, did not fully reflect the diverse culture of people the service could support. The registered manager told us they would make contact with the provider to look at how they could improve information made available to people. A staff member told us they had no issues about speaking with people about their sexuality or supporting them with this to make sure their needs were met. Following our visit the registered manager told us they had

made contact with Age UK who arranged social gatherings and meetings to support older people to talk about their sexuality and any support they may need.

People's religious needs were considered and the provider had a "Spiritual Care Procedure". This provided staff with guidelines on how to support people with different religions. The registered manager told us how they planned to improve people's mental, physical, spiritual and cultural needs. They had been working through people's care records to see how people needed to be supported so they could ensure people received person centred care. For example, they had identified that one person liked to attend church services each week and some people wished to receive communion. A nun visited the service to provide communion to those people who had requested this. The registered manager told us they were looking at sourcing a minister locally to complete a service with people at the home. There was one person who had asked for their hair to be done in a certain way but the hairdresser who worked at the home was unable to provide this service. The registered manager therefore had made arrangements for another hairdresser to do this.

Care records viewed showed that people had been asked about their wishes when they were at the end of life so that these could be accommodated by the home.

People told us there were activities provided at the home but some said they would like to be out more. One person told us, "I would like to be out and about a bit more, they don't think enough of things to do, they don't anticipate people's needs." Social activities were provided at the home although the wellbeing co-ordinator who organised these had recently left and the post was vacant. Staff told us social activities were provided on most days but outside visits were limited depending on if there were staff available. One staff member told us, "We did go to another home and took a few residents, we put music on, they had dinner, they sat down with a choc ice and watched a film and they really enjoyed that. [Person] said he enjoyed it, he likes to go out. They have been on bowling trips in the past."

There was a mini bus available to the home so that people could go out on trips and we were told people had been on trips to Blackpool, the zoo and the Black Country museum. The registered manager told us of plans to employ another wellbeing co-ordinator to plan and provide social activities to people which would include taking people on visits or trips outside of the home. They told us, "We are trying to involve them (people) more in the community. We are looking at having coffee mornings and inviting people from local churches and sheltered housing so they can come and spend time with us and get to know the residents and get to know what Victoria manor is like as a home."

During out visit there was a social activity that took place with an outside provider. A range of small animals were brought into the home including a hedgehog, large snail and a Gecko for people to touch and hold if they wanted. The person who provided the activity told people about the animals and we saw people smiling and asking questions about them. The activity generated discussion between people and they talked about it throughout the afternoon demonstrating this had been something they had enjoyed. One person who did not attend the activity because they did not like going up to the first floor in the lift, asked if the person could bring the animals down once they had finished talking about them to people on the first floor. We saw the activity person visit the person on the ground floor as requested.

Staff showed us that access to the garden had been improved after people had said they were getting tired by having to walk to the end of the corridor where the outside door was situated. Another access had been arranged from the ground floor lounge directly into the garden and new garden furniture had been purchased so people could enjoy sitting outside. A bench had been placed at one end of the corridor and a sensory space at the other end so that people could use these spaces if they wanted to go somewhere

quieter. The sensory space had a pram and dolls that people could use if they wished (doll therapy is recognised as helpful for people who live with dementia) and the various objects on the walls of the corridors showed the provider had considered the needs of people with dementia.

People who lived at the home we spoke with told us they never had cause to make a complaint. When we asked people who they would raise a complaint with, they were not always clear they could talk to staff or the management team. For example, one person told us this would speak with another person at the home who they referred to as their 'friend' as opposed to staff. We saw there was a complaints process on display to support people and visitors to raise any concerns. This included information about external organisations people could approach if they were not happy with how their complaint had been responded to. We saw other complaints received by the home had been acted upon and responded to. However, the relatives of one person told us they had not been satisfied with how their concerns had been managed by the service and they had therefore raised a formal complaint.

The relative told us they had made repeated requests of staff which had not been carried out. This included requests in relation to the storing of laundry in the person's room to prevent the spread of infection, the application of cream to the person's skin when needed, and following up on health professional visits including one to address the person's dental concerns. They also had reported items missing from the person's room that had not been located. We saw a response had been made to the person and an apology made for failures to address these concerns effectively at the time they had occurred. The provider had taken action to request actions of both the registered manager and staff to ensure these concerns were addressed to prevent them reoccurring in the future. We saw the provider had offered to meet with the family to ensure they were satisfied with the investigation that had taken place to address their concerns.

Good

Is the service well-led?

Our findings

At this inspection, we found the service and staff continued to be as well-led as we had found during the previous inspection. The rating continues to be Good.

People and visitors were generally positive in their comments of the home, for example, a relative told us, [Staff member] is an amazing carer she is a rarity, she is just doing her job." Another relative told us the care was "not so good" when agency staff were on duty. They told us the registered manager had been addressing the staffing arrangements in the home so that there was less reliance on agency staff.

Following the last inspection there had been changes to management at the home in that a new manager and deputy manager had been recruited. The manager had been recruited in June 2017 and registered with us in August 2017. The registered manager was supernumerary (not counted in the numbers working in the home) so they could focus on management duties.

The provider had systems and processes in place to help ensure staff worked to the required policies and procedures. Regular audit checks were carried out at the home such audits of falls and people's weights so that any concerns were identified and addressed. An internal inspection of the home by a member of the provider's management team was also carried out approximately every eight weeks. Following a visit undertaken by them in September 2017, we saw the registered manager had put together an action plan to address the issues identified. The action plan contained timescales for completion and showed actions that had been undertaken. For example, where people had lost weight there was an action to check people's weight weekly and provide fortified diets (add additional calories) and extra snacks. We saw this was being done. Where there were issues with records completion including medicine records, there was an action for these to be discussed at staff meetings.

The provider's area director visited the home regularly to support the manager and to ensure the home was running effectively. The registered manager told us they felt supported by the management team and were aware of the key challenges for the home as a result of the quality monitoring processes the provider had implemented.

Health and safety checks had been carried out including checks of the gas, electricity, water and fire alarms to make sure the premises and environment was safe. Checks associated with the fire risk assessment to keep the home safe had also been carried out. The service worked with other agencies such as fire authorities, local authority commissioning teams (who funded some people's care), and health professionals to ensure people's health, safety and wellbeing were maintained.
There were checks undertaken of accidents and incidents so that trends could be analysed and lessons learnt to help prevent them from happening again.

Wi-Fi was available at the home to support people to keep in touch with their families via skype if they wished and people were able to share their views of the service at 'relative and resident' meetings. However, we were told these meetings were not always well attended. To address this, the registered manager told us

they planned to implement a newsletter they could make available to relatives.

The provider had implemented a quality monitoring process called "Have your Say." This was a computer tablet based in the entrance hall for people, relatives, care professionals and staff to use to provide feedback about the home. Comments people made about the service were kept in a quality assurance folder so the registered manager could ensure any areas for action were identified and addressed.

Staff had a clear understanding of their roles and responsibilities and what was expected of them. Staff were generally positive about working at the home and described how they worked as a team to help ensure people received effective care. One staff member told us, "The home is not 100% perfect but the level of care is very good." Another staff member told us, "I feel well supported, we all get along, the carers help each other." This staff member also told us, "The support from our manager is okay, she is approachable." We saw a senior care staff member advising care staff at the beginning of the day which floor they would be working on and saw when staff were busier on one floor, staff from the other assisted them. This demonstrated staff worked as a team to support the needs of people at the home.

Staff told us if they had any concerns they would go to their manager for support. One staff member told us they had felt comfortable to raise a concern with the registered manager about staffing arrangements. They told us, "She is a good manager, I like her and feel I can get on well with her. I feel I could tell her a problem."

The registered manager told us how they valued staff at the home and hoped that staff felt valued. They told us this was communicated to them at staff meetings. Staff told us they had regular staff meetings which provided them with an opportunity to raise any concerns or provide feedback or ideas about how the service could be improved. One staff member told us, "It can be an eye opener, some staff are vocal, which is very good." Another told us, "Yes we can share opinions and views, they do make changes. [Manager] has been getting a couple of staff in downstairs for about ten minutes to discuss little things so if there are things you are not sure of, we can all discuss it." The staff member went on to tell us about a change that had occurred as a result of them speaking with the registered manager. They said there was a person who had not been eating well because of the way they were sat in their chair, the position of their head made it difficult for them to eat. The staff member had suggested to the registered manager the person may benefit from being assisted with food in bed and this was agreed. They told us this had resulted in a positive outcome for the person.

We saw the provider had implemented a 'simplicity project' where staff were asked about three things which would make their life easier. One staff member had requested for some of the care documentation to contain pre-printed information on it to save them time writing repeated information. We saw the provider had acted on this where it was safe and appropriate to do so.

There was a 'kindness in care' initiative where people could nominate staff for an award. We saw one person had put forward a nomination for a staff member. The registered manager told us if a staff member was selected by the company, they received a money voucher and a thank you letter from the Chief Executive. They told us the provider also issued spontaneous awards for staff, where for example, they could receive a 'thank you' post card.

We saw that Healthwatch representatives had visited the home in October 2017. Healthwatch carry out visits to health and social care providers such as care homes to make sure that those running services put people first and at the heart of care. They can make recommendations to care provider's that could to help improve people's experiences of care. The Healthwatch report of the visit in October 2017 showed people

experienced positive outcomes. Where recommendations had been made, these had been taken seriously and plans to address them had been made. For example, there were plans to improve social activities made available to people once a new wellbeing co-ordinator was appointed.