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Victoria Hall

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 30 April 2018 and was unannounced. We returned on the 01 May 2018 to complete the inspection. The management team was given notice of the second date, as we needed to spend specific time with them to discuss aspects of the inspection and to gather further information.

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

Victoria Hall is registered to accommodate 37 people in one adapted building. There were 20 people living in the service at the time of our inspection visit.

There was a registered manager in post. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations.

At the last inspection on 11 and 13 July 2017 the service was rated 'Inadequate.' The report was published in October 2017. At that inspection we identified five regulatory breaches' of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was due to the registered manager not fully assessing the risk to the health and safety of people using the service. The registered manager was not able to demonstrate that they had sufficient numbers of staffing at all times to ensure people's physical and social needs were adequately met. People were not being adequately supported to have enough to eat and drink and there was poor monitoring of this. The registered manager was unable to demonstrate through her records how they provided individualised care based on the accurate assessment of people's needs. Systems and processes were not sufficiently robust and were not identifying areas requiring improvement.

We also found the service was in breach of one regulation of the Care Quality Commission (Registration) Regulations 2009. This was due to the service failing to notify us of significant incidents in a timely way.

Since our last inspection, we have continued to engage with the registered manager. We required the registered manager to complete an action plan to show what they would do and by when to improve the key questions is the service safe, effective, caring, responsive and well-led to at least good.

At this inspection in April and May 2018, we confirmed that the registered manager and provider had taken sufficient action to address previous concerns and comply with required standards. As a result, at this inspection we found significant improvements had been made and maintained, resulting in the overall rating of the service being changed to, 'Good'.

This service has been in Special Measures. Services that are in Special Measures are kept under review and

inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

At this inspection for the key question is the service 'well led' we have rated it as 'Requires Improvement'. We found although there were significant improvements in the care planning, time was still needed to ensure they were accurate and fully completed. The provider agreed with our findings and gave a target of May 2018 for completion.

Although at this inspection quality checks had been completed to ensure people benefited from the service being able to quickly put problems right and to innovate so that people consistently received safe care, the previous inspections published in June 2015, September 2016 and November 2017 had identified variable quality and compliance issues. That in some cases the "good" practice had not been sustained over time as a result of gaps in quality monitoring and good governance. Therefore further time and work was needed on behalf of the provider to ensure that "good" practice found at Victoria Hall at this inspection would be sustained through robust and continuous quality monitoring and support.

Staff had received training of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS). This was also covered as part of their dementia training. Our observations confirmed staff promoted choice and acted in accordance with people's wishes. However, not all staff demonstrated a clear knowledge of the MCA and DoLS in our discussions with them. We fed back to the registered manager that staff would benefit from further training. The registered manager gave reassurances staff would be given additional training specifically on the MCA and DoLS by September 2018. The registered manager also gave MCA information cards for all staff to carry on them, to refresh their knowledge, during our visit.

There were systems, processes and practices to safeguard people from situations in which they may experience abuse. Risks to people's safety had been assessed, monitored and managed so they were supported to stay safe while their freedom was respected. In addition, the necessary provision had been made to ensure that medicines were managed safely. Suitable arrangements had been made to ensure that sufficient numbers of suitable staff were deployed in the service to support people to stay safe and meet their needs. Background checks had been completed before care staff had been appointed. People were protected by the prevention and control of infection and lessons had been learnt when things had gone wrong.

Suitable arrangements had been made to obtain consent to care and treatment in line with legislation and guidance. Care staff had been supported to deliver care in line with current best practice guidance. People enjoyed their meals and were supported to eat and drink enough to maintain a balanced diet. In addition, people had been enabled to receive coordinated and person-centred care when they used or moved between different services. As part of this people had been supported to live healthier lives by having suitable access to healthcare services so that they received on-going healthcare support. Furthermore, people had benefited from the accommodation being adapted, designed and decorated in a way that met their needs and expectations.

People were treated with kindness, respect and compassion and they were given emotional support when needed. They were also supported to express their views and be actively involved in making decisions about their care as far as possible. Confidential information was kept private.

People received personalised care that was responsive to their needs. Care staff had promoted positive

outcomes for people who lived with dementia including occasions on which they became distressed. People's concerns and complaints were listened and responded to in order to improve the quality of care. In addition, suitable provision had been made to support people at the end of their life to have a comfortable, dignified and pain-free death.

There was a positive culture in the service that was open, inclusive and focused upon achieving good outcomes for people. People benefited from there being a management framework to ensure that staff understood their responsibilities so that risks and regulatory requirements were met. The views of people who lived in the service, relatives and staff had been gathered and acted on to shape any improvements that were made. Good team work was promoted and staff were supported to speak out if they had any concerns about people not being treated in the right way. In addition, the management team worked in partnership with other agencies to support the development of joined-up care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Care staff knew how to keep people safe from the risk of abuse.

People had been supported to avoid preventable accidents and untoward events.

Medicines were safely managed.

Suitable arrangements had been made to ensure that sufficient numbers of suitable staff were employed to support people.

People were protected by the prevention and control of infection and lessons had been learnt when things had gone wrong.

Is the service effective?

Good

The service was effective.

Staff had received an overview of the Mental Capacity Act (MCA) as part of their dementia training and our observations confirmed staff promoted choice and acted in accordance with people's wishes. However, not all staff demonstrated a clear knowledge of the MCA or with the Deprivation of Liberty Safeguards (DoLS)

People enjoyed their meals and were helped to eat and drink enough to maintain a balanced diet.

People received coordinated care when they used different services and they had received on-going healthcare support.

The accommodation was adapted, designed and decorated to meet people's needs and expectations.

Is the service caring?

Good

The service was caring.

People were treated with kindness, respect and compassion and they were given emotional support when needed.

People were supported to express their views and be actively involved in making decisions about their care

People's privacy, dignity and independence were respected and promoted.

Confidential information was kept private.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs.

Positive outcomes were promoted for people who lived with dementia.

People told us that they were offered the opportunity to take part in a range of social activities.

People's concerns and complaints were listened and responded to in order to improve the quality of care.

Suitable provision had been made to support people at the end of their life to have a comfortable, dignified and pain-free death.

Is the service well-led?

Requires Improvement

The service was not always well led.

Care plans were in varying stages of completion. This resulted in records not always being accurate or complete.

Victoria Hall demonstrated most of the characteristics of good leadership. However further time and work is required to ensure that their systems for monitoring and improving services are embedded and to demonstrate that "good" practice can be sustained over time.

There was an open culture and people benefited from staff understanding their responsibilities so that risks and regulatory

requirements were met.

People who used the service, their relatives and staff were engaged and involved in making improvements.

There were suitable arrangements to enable the service to learn, innovate and maintain its sustainability.

Quality checks had been completed and the service worked in partnership with other agencies.

Victoria Hall

Detailed findings

Background to this inspection

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

We visited the service on 30 April 2018 and the inspection was unannounced. We returned on the 01 May 2018 to complete the inspection. On the first day the inspection team consisted of two inspectors. There was also an expert by experience. An expert by experience is a person who has personal experience of using this type of service. On the second day one inspector completed the inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We reviewed information we held about the service, including safeguarding concerns shared with us from the local authority, previous inspection reports and notifications of significant events the provider sent to us. Notifications are events that the provider is required by law to inform us of.

Due to the nature of people's complex needs, we were not able to ask everyone direct questions. We spent time observing people in areas throughout the home to see interactions between people and staff. We observed people as they engaged with their day-to-day tasks, the care they experienced, including the breakfast and lunchtime meal, medicines administration and activities.

We spoke with six people who lived in the service and with three relatives. We spoke with the registered manager and assistant manager. We also spoke with three members of care staff, one activity co-ordinator and the chef.

We looked at the care plans and associated records for eight people, including medicine records. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents and incidents, menu's, relative questionnaires, and health and safety checks. Records for three staff were reviewed, which included checks on newly appointed staff and staff supervision records.

Good

Is the service safe?

Our findings

At the last inspection in July 2017 we rated this key question as 'Inadequate'. We found three breaches of regulation. The provider had failed to ensure that care and treatment was provided in a safe way. They had not assessed all risks to people's safety or taken appropriate actions to mitigate these risks. The management of the service had failed to have sufficient numbers of staff. The service failed to notify us of significant incidents in a timely way.

We made requirements for this to be addressed and the provider sent us an action plan. At this inspection, we found improvements had been made and these regulations were now met, resulting in the rating being changed to, 'Good'.

People who were able to told us they felt safe and our observations confirmed people who were unable to initiate communication were regularly asked throughout our visit if they were comfortable. Staff confirmed that people who appeared upset or not their usual selves were checked to see if they were in pain or needed assistance, which we observed.

One person said, "I feel safe and comfortable here, because everyone is supportive. It feels like a family and I am confident that if I were worried they [staff] would say, 'Why didn't you tell us?'". Another person said, "I'm safe and comfortable because I have my bell." A third person told us, "I feel very safe living here. The carers make sure I take my medication, as I should. They support me with my mobility, making sure I do not fall. When I need them, they help me, nothing is too much bother."

A relative told us, "[Person] is well looked after and I have complete trust in the staff."

We found that risks to people's safety had been assessed, monitored and managed so they were supported to stay safe while their freedom was respected. This included measures that had been taken to help people avoid preventable accidents. We saw that hot water was temperature controlled and radiators were guarded to reduce the risk of scalds and burns. In addition, people were provided with equipment such as walking frames and raised toilet seats to reduce the risk of falls.

We viewed eight people's care records which included risk assessments regarding nutrition, possible falls, diabetes, choking and the risk of skin damage. There were also risk assessments regarding negative behaviours people might exhibit. There were corresponding care plans to show how the risks were to be mitigated and instructions for staff.

We were told about people who had dysphagia. This is the medical term used for people who have difficulty swallowing. People with dysphagia need support to reduce the risk of choking. The care records confirmed they had this condition and detailed measures needed to reduce risks of choking. For example, that the person needed a pureed diet, that fluids should be thickened, sat in an upright position when eating and monthly checks of their weight. We spent time with this person and the member of staff who was supporting them. The member of staff was able to explain the support the person needed to eat safely which

corresponded with the contents of the care records. The member of staff was also able to explain signs of choking such as coughing, change of facial colour and general discomfort. They were also aware of what to do if choking occurred. This included giving emergency first aid.

Moving and handling assessments gave staff clear guidance on how to support people when moving them. We observed people were safely moved from chairs to wheelchairs and to sit at the dining table. We observed staff communicating with people during transfers to check people felt safe and comfortable. One staff member said, "That's OK, you're fine, well done." We noted suitable equipment such as hoists and wheelchairs were available for staff to use and each sling was for one person's use only.

Risks regarding falls and developing pressure areas on skin due to prolonged immobility were completed. Appropriate referrals had been made to health care services. These included referrals for assessment by the tissue viability service regarding pressure area care, and, physiotherapy services where people were at risk of falls.

Two people had a record to show they were repositioned at regular intervals to relieve the pressure on their skin due to prolonged immobility. The care plan included instructions of how often this repositioning should take place.

The premises were purpose built and the layout was such that it did not present significant difficulties in evacuating people in the event of an emergency. People had individual Personal Emergency Evacuation Plan (PEEP) in place on how they should be supported to evacuate the building in the event of a fire. An environmental risk assessment was in place which identified risks to people, staff and visitors. Daily, weekly and monthly health and safety checks were carried out. Fire drills took place and equipment such as fire, electrical, moving and handling equipment was serviced and fit for purpose.

The registered manager told us that suitable arrangements had been made to ensure that sufficient numbers of suitable staff were deployed in the service to support people to stay safe and meet their needs. We saw that the registered manager had established how many care staff needed to be on duty at each time of day based upon an assessment of the care each person required. This was reviewed as a minimum monthly. We were told that there were always five carers and one senior carer in the building from 8am to 8pm. Rotas we sampled reflected what we had been told.

Records showed the planned deployment of care staff had always been met. They also showed that on most days the number of care staff on duty had met the minimum level that the registered manager considered to be necessary. Although we were told that a small number of care staff shifts had not been filled in the month preceding our inspection visit, we concluded that in practice there had been enough care staff on duty to provide people with the assistance they needed. This was because we were assured that when care shifts had not been filled members of the management team and other members of staff worked flexibly either to provide care themselves or to relieve care staff from having to undertake non-essential duties.

The registered manager told us if agency staff were needed, they were allocated from an approved list. To ensure people were supported safely, we were told, they requested specific agency staff who knew the home to cover shifts and records confirmed this. Records confirmed that agency staff received an induction when first working at the home and given sufficient information about people who lived at the home to provide safe care. This included information about moving and handling and eating and drinking.

In addition to the care staff, the service had one housekeeper each day from either 7am to 2pm or 8am to 2pm. Records sampled showed us that housekeeping staff were also given the same training as care staff,

which enabled them to provide additional support and cover any shortages if needed. The service had one chef each day from 7.30am to 2pm, with care staff providing tea in the afternoons. There was one activity coordinator who worked Monday to Friday. When the activity coordinator had agreed leave, we were told the activities were covered by the assistant manager. We viewed records over the past 12 months that confirmed what we had been told. This enabled the care staff to attend to people and their needs.

Recruitment practices were robust. Staff files showed references were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting. There were records to show staff were interviewed to check their suitability to work in a care setting.
We noted that the registered manager had correctly told us about significant events that had occurred in the service. These included promptly notifying us about possible safeguarding incidences.

There were systems, processes and practices to safeguard people from situations in which they may experience abuse. Records showed care staff had completed training and had received guidance in how to protect people from abuse and this was included in the induction for newly appointed staff. We found that care staff knew how to recognise and report abuse so that they could take action if they were concerned that a person was at risk. They told us they were confident that people were treated with kindness and they had not seen anyone being placed at risk of harm.

At this inspection we found that the necessary arrangements had been made to ensure the proper and safe use of medicines. There were reliable arrangements for ordering, administering and disposing of medicines. There was a sufficient supply of medicines and senior care staff who administered medicines had received training. Records demonstrated arrangements had been made for all trained staff to be assessed to ensure their competence to undertake this annually. This is an observation of how staff safely handle and administer medicines, which is recommended in the Royal Pharmaceutical Society guidance, 'The Handling of Medicines in Social Care.' We saw them correctly following the provider's written guidance to make sure that people were given the right medicines at the right times.

We observed that unused medicines were discarded safely and in accordance with the administration of medicines policy. Stocks of medicines showed people received them as the prescriber intended. When people had their medicines administered on an 'as required' basis there was a protocol for this which described the circumstances and symptoms when the person needed this medicine. The temperature of the medicines storage room was monitored as was the temperature of the fridge used to store medicines. These were within the recommended safe limits.

There were suitable systems to protect people by the prevention and control of infection. Records showed that the management team had assessed, reviewed and monitored what provision needed to be made to ensure that good standards of hygiene were maintained in the service. We found that the accommodation was clean and had a fresh atmosphere. We also noted that equipment such as hoists and commodes were in good condition, had washable surfaces and were clean. In addition, we noted that soft furnishings, beds and bed linen had been kept in a hygienic condition. Overall we saw that care staff recognised the importance of preventing cross infection. They were wearing clean uniforms, had access to antibacterial soap and regularly washed their hands.

We found that the registered manager had ensured that lessons were learned and improvements made when things had gone wrong. Records showed that they had carefully analysed accidents and near misses so that they could establish how and why they had occurred. We also noted that actions had then been taken to reduce the likelihood of the same thing happening again. These actions included considering the

need to refer people to specialist healthcare professionals who focus on helping people to avoid falls. They also included practical measures such as when using agency staff they are always paired with an experienced carer who was employed by the service.

Environmental Health visit care establishments and inspect food preparation facilities. This is called a "FHRS", giving a rating from zero to five, zero being the worst and five being the best. Victoria Hall had previously been rated two, since this rating the registered manager had reviewed the areas that required improving, both in staff knowledge and the cleanliness of the premises. The registered manager ensured regular 'deep cleans' took place by an external contractor. Environmental Health have since re-inspected Victoria Hall and the service had been rated as a five, being the best.

Good

Is the service effective?

Our findings

At the last inspection in July 2017 we rated this key question as 'Requires Improvement'. We found two breaches of regulation. People were not being adequately supported to have enough to eat and drink and there was poor monitoring of this. We found records did not always fully document people's needs or how they were being met or changes identified.

We made requirements for this to be addressed and the provider sent us an action plan. At this inspection, we found improvements had been made and these regulations were now met, resulting in the rating being changed to, 'Good'.

One person told us, "All the carers understand how I feel and what my needs are. When they help me they normally do it in a kindly, gentle manner and very efficiently too. There are always two of them to help me into my wheelchair. They call me by name and ask permission before doing things for me." Another person told us, "They [Carers] know how to help me into the hoist without any problems. The meals are excellent. Yesterday we had a roast beef dinner, and then there was strawberry cheesecake. It was like being at a restaurant." Our observations showed staff were confident and knew how to support people in the right way.

One relative told us, "The carers all know about and understand [person's] condition. They do encourage them to stand, to keep them independent." A second relative told us, "People with dementia are treated well. The staff support each other, the care plans cover how to support people, I'm aware of the care plan and I've read it." A third relative told us, "The food looks good to us and even when pureed, the different ingredients are put separately on the plate."

We were present at lunch time and we noted that the meal time was a relaxed and pleasant occasion. The dining tables were neatly laid, people were offered a choice of dishes and the meals were attractively presented. The service had a menu plan which showed varied, nutritious and balanced meals. People were offered a choice of food and were asked in advance what they wanted to eat which was recorded for the kitchen staff to follow. Stocks of food included fresh vegetables and fruit and the chef told us dishes were homemade from fresh ingredients. We observed people's likes and dislikes were documented and kept in the kitchen, accessible to staff. The chef received written information from care staff about people's preferences and requirements when someone came to live at the home.

People's nutritional needs were assessed and care plans recorded where people needed support with eating and drinking. Where people had problems with eating and drinking, referrals were made to the GP, dietician or Speech and Language Therapist (SALT). Copies of SALT reports were included in people's care records so staff knew the type of support people needed. People had been offered the opportunity to have their body weight regularly checked so that any significant changes could be brought to the attention of a healthcare professional. People had been assessed, using a combination of height, weight and body mass index, to identify whether they were at risk of malnourishment. The registered manager had completed these assessments using the Malnutrition Universal Screening Tool (MUST), a tool designed specifically for

this purpose. Some people's food and fluid intake was monitored, which was recorded and showed people had sufficient to eat and drink. People's weight was monitored and recorded. The care plans, monitoring charts and information in people's rooms was accurate and reflected the care we observed them receiving.

We found that robust arrangements were in place to assess people's needs and choices so that personal care was provided to achieve effective outcomes. Records showed that the registered manager had carefully established what assistance each person needed before they moved into the service. This had been done to make sure that the service had the necessary facilities and resources. Records also showed that the registered manager's assessment had suitably considered any additional provision that might need to be made to ensure that people did not experience discrimination. An example of this was the registered manager clarifying with people if they had a preference about the gender of the care staff who provided them with close personal care.

One person told us, "Staff involve me every day in how I want my care delivered and when I want my care delivered. They listen to me." Throughout our inspection, we saw that people, where they were able, expressed their views and were involved in decisions about their care and support. We observed staff seeking consent to help people with their needs.

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).

Appropriate DoLS applications had been made, and staff acted in accordance with DoLS authorisations. Where Deprivation of Liberty Safeguards decisions had been approved, we found that the necessary consultation had taken place. This had included the involvement of relatives and multi-disciplinary teams. We checked people's files in relation to decision making for those who were unable to give consent. Documentation in people's care records showed that when decisions had been made about a person's care, where they lacked capacity, these had been made in the person's best interests.

Staff had received training of the MCA and DoLS and as part of their dementia training. Our observations confirmed staff promoted choice and acted in accordance with people's wishes. However, not all staff demonstrated a clear knowledge of the MCA and DoLS in our discussions with them. We fed back to the registered manager that staff would benefit from further training. The registered manager gave reassurances staff would be given additional training specifically on the MCA and DoLS by September 2018. The registered manager also gave MCA information cards for all staff to carry on them, to refresh their knowledge, during our visit.

All new staff were required to complete the Care Certificate, covering 15 standards of health and social care topics. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. This ensured people received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. Inductions also included areas such as the geography of the home, communication systems, policies and procedures.

The registered manager maintained a spreadsheet record of training in courses completed by staff which

the provider considered as mandatory to providing effective care. This allowed the registered manager to monitor when this training needed to be updated. These courses included food hygiene, fire safety, first aid, health and safety, infection control, moving and handling, equality and diversity and medication. Additional training was available to staff in specific conditions such as care of the dying, nutritional needs, record keeping, challenging behaviours, dementia, continence care and person centred care. Staff also received on-going refresher training to keep their knowledge and skills up to date. We found that care staff knew how to care for people in the right way. An example of this was care staff knowing how to provide clinical care for people who lived with particular medical conditions. Other examples were care staff knowing how to correctly assist people who experienced reduced mobility or who needed help to promote their continence.

Staff were supported to attain the National Vocational Qualification (NVQ) in care or the Diploma in Health and Social Care. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard.

Without exception all of the staff we spoke with, told us teamwork among the care staff was positive and that morale was good. They all stated that the care home was a good place to work and that they felt staffing levels were satisfactory based upon the number of people living at Victoria Hall at present.

Staff received monthly supervisions with the registered manager or assistant manager and notes of supervision meetings confirmed this. Staff told us they found supervision meetings helpful. We reviewed records of staff supervision which noted that the focus was clearly on staff welfare. It was evident staff could raise issues of importance to them. The staff we spoke with confirmed this. We found records demonstrating other ways staff were supported. This was through staff monthly meetings. Minutes of these discussions demonstrated staff discussed peoples' needs, activities, changing policies and procedures, safeguarding and training needs. Without exception, staff told us this worked for their service and that the registered manager had an open door policy where they could talk to them anytime they needed to. It was clear staff possessed a high degree of knowledge about the people they were caring for. This was confirmed in our discussions with staff.

Suitable arrangements had been made to ensure that people received effective and coordinated care when they were referred to or moved between services. An example of this included care staff readily having to hand over important information about a persons' care so that this could be given to ambulance staff if someone needed to be admitted to hospital.

People were supported to live healthier lives by receiving on-going healthcare support. Records confirmed that people had received all of the help they needed to see their doctor and other healthcare professionals such as dentists, opticians and dieticians.

We found that people's individual needs were suitably met by the adaptation, design and decoration of the accommodation. There was sufficient communal space in the dining room and in the lounges. In addition, there was enough signage around the accommodation to help people find their way around. Everyone had their own bedroom that was laid out as a bed sitting area so that people could spend time in private if they wished. Furthermore, people told us that they had been encouraged to bring in items of their own furniture and we saw examples of people personalising their bedrooms with ornaments, personal memorabilia and photographs.

Good

Is the service caring?

Our findings

At the last inspection in July 2017 we rated this key question as 'Requires Improvement'. We observed some kind and caring interactions but this was not seen consistently across all the staff. The service did not sufficiently take into account people's wishes and preferences.

At this inspection, we found improvements had been made and maintained, resulting in the rating being changed to, 'Good'.

One person told us, "I get a bit spoilt. I am nice and they are nice back. We talk about the village and where I used to live. You can see the planes and we will talk about them. [Carer] is lovely, she lived not far my own village. They don't talk about other people in front of me." Another person told us, "The carers are fine with me. They chat and ask me if I have any problems and they will try to sort it if they can. They encourage me to help myself."

One relative told us, "The staff recognise us and tell us how [person] is doing. We chat to them and feel welcome." Another relative told us, "The carers are respectful and very friendly and kind and decent. They are a team in here. I spoke to [activities coordinator] who runs the activities and told him I'm glad he is here. He has a real commitment. The staff talk to me and are friendly towards me." A third relative told us, "I have visited this home for years, on a regular basis, and I have never seen anything untoward. The staff do their best, they are really caring and take their time, paying attention to detail. I always see them checking the folks have their glasses on, hearing aids and are comfortable."

We observed the way staff and people interacted and the care that was provided. Our observations showed us people were positive about the care and support they received. People smiled, laughed, nodded their heads and told us they liked the staff. All interactions we saw were comfortable, friendly, caring and thoughtful. Staff behaved in a professional way. People enjoyed the relaxed, friendly communication with staff. There was a good rapport between people; they chatted happily between themselves and with staff. When staff assisted people, they explained what they were doing first and reassured people.

Records indicated there were a number of people with a diagnosis of dementia, we observed staff interacting effectively with people with in a calm, friendly manner. Throughout the inspection the atmosphere was relaxed and there was no evidence of people experiencing distress.

We saw that the service ensured that people were treated with kindness and that they were given emotional support when needed. Care staff were informal, friendly and discreet when caring for people. We witnessed positive conversations that promoted people's wellbeing. An example of this occurred when we overheard a carer talking to a person, taking time to listen to them and making comments with some humour involved. The conversation was unrushed. Staff spoke with people as they went about their work and spent time with people who were cared for in their rooms. We observed staff kneeling down to speak with people, stroking their arms and backs and calling them by their names.

We noticed that care staff had sensitively asked people how they wished to be addressed and had established what times they would like to be assisted to get up and go to bed. Another example was people being consulted about how often they wished to be checked at night. People were asked if they would prefer a bath or shower. Whether people wanted to be supported with having a wet or electric shave. Records demonstrated that choices were being met and documented.

Personal histories had been completed for people and provided staff with information about people's earlier lives, their food likes and dislikes, travel, music and activities they liked to do. Any special dates were also recorded, so staff could support people to remember happy times or sad times. This enabled staff to see what was important to the person and how best to support them.

We found that people had been supported to express their views and be actively involved in making decisions about their care and treatment as far as possible. Most people had family and friends who could support them to express their preferences. Care plans included people's preferences around clothes and gender of care staff they wished to be supported by.

People's privacy, dignity and independence were respected and promoted. We noted that care staff recognised the importance of not intruding into people's private space. Bedroom, bathroom and toilet doors could be locked when the rooms were in use. In addition, people had their own bedroom that they had been encouraged to make into their own personal space. We also saw care staff knocking and waiting for permission before going into bedrooms, toilets and bathrooms.

We found that people could speak with relatives and meet with health and social care professionals in private if this was their wish. In addition, care staff were assisting people to keep in touch with their relatives by post and telephone.

Suitable arrangements had been made to ensure that private information was kept confidential. We saw that written records which contained private information were stored securely when not in use. In addition, computer records were password protected so that they could only be accessed by authorised members of staff. Records showed that care staff had been given training and guidance on the importance of maintaining confidentiality and we found that they understood their responsibilities in relation to this matter.

Good

Is the service responsive?

Our findings

At the last inspection in July 2017 we rated this key question as 'Requires Improvement'. People did not always receive personalised care which was responsive to their needs. Concerns and complaints were dealt with in a timely manner but not always responded to in a positive way. Staff did not sufficiently support people to take part in regular activities.

At this inspection, we found improvements had been made and maintained, resulting in the rating being changed to, 'Good'.

We found that people received personalised care that was responsive to their needs. This was demonstrated through our observations and from information people and staff shared with us. Although there were significant improvements in the care planning, time was still needed to ensure they were accurate and fully complete. We found this had not impacted people and have therefore covered this in the key question, is the service well led?

People told us, staff had carefully consulted with them about how they wanted their personal care delivered. Overall care plans were being reviewed monthly to make sure that they accurately reflected people's changing needs and wishes. All three relative's told us, since their loved one's had resided at Victoria Hall they have been fully involved in all of the care reviews.

Other records confirmed that people were receiving the personal care they needed as described in their individual care plan. This included help with managing a number of on-going medical conditions, washing and dressing, changing position safely and promoting their continence.

We saw that care staff were able to promote positive outcomes for people who lived with dementia. The management team had made appropriate referrals to the Dementia and Intensive Support Team (DIST) when required. The DIST team offer assessment and interventions for adults with age related needs suffering from mental health problems including anxiety, depression, confusion and dementia.

People told us that they were offered the opportunity to pursue their hobbies and interests and to enjoy taking part in a range of social activities. One person told us, "I read and knit. The activity co-ordinator comes to my room for a chat and I have also been in the lounge and played ball games." Another person told us, "I get in the garden when the weather's better. We get visitors come in to perform at times like Easter and Christmas. I knit and watch TV and maybe join in the skittles."

Other people told us, they did not enjoy doing activities and felt staff respected their choices when wanting to be left alone. One person told us, "I don't really want to take part in activities. I just do not seem to have the willpower or the interest. They try to encourage me. I do not get bored as I can look out of my window. Staff will pop their heads round the door to make sure I am ok."

On the day of our visit the activities coordinator in the morning was observed organising a balloon exercise.

A balloon was tossed between people; we observed laughter and people smiling. In the afternoon a game of skittles was enjoyed by five people while two other people looked on smiling. The enthusiasm and cheery nature of the coordinator was obvious and this was picked up by people, who smiled and gave appreciation when a strike was made. A large soft ball was used and this could be rolled down one person's leg, who we observed had limited mobility so they could participate. The coordinator praised and encouraged people throughout. If he noticed someone was struggling, he would say things such as, 'Come on (name), you haven't had a go for a long time.' Following this, the activities coordinator brought in a CD with 'age appropriate' tunes and he joined in, accompanied by two staff and two people. He pointed out to the carers, '(Name) did really well earlier, they got all skittles down in one.' The person smiled.

A hairdresser was on site who visited weekly. We observed many people popping in the salon for their hair appointments.

We saw that suitable provision had been made to acknowledge personal milestones. An example of this was people being helped to celebrate their birthdays in a manner of their choice which usually involved the chef baking them a special cake.

Additionally staff completed 'resident of the day' photos books each month. These were photo diaries of how a person was supported with an important event to the person and how other people at Victoria Hall were included in the event. For example, in October 2017, a person who used to race horses, keep horses and attend horse events, had 'A day at the races'. People and staff wore racing hats, medals, rosettes and used horse heads, on a stick to race each other. A special menu was put together for the day and photos taken of each person's reaction. In November 2017, another person who used to live and work on a farm, had 'A day at the farm'. Remote controlled tractors were purchased and people raced them. Photo books were purchased of farms and people were encouraged to consider what life would have been like for the person. The person also shared what life was like for them on the farm. In December 2017, a person who used to work at a school as a dinner lady had 'A baking day'. Everyone was supported to bake cakes and biscuits. This demonstrated the registered manager and staff went the extra mile in getting to know people. They encouraged what they knew was important to a person and made it relevant in todays time. We found this to have had a positive impact on people living at Victoria Hall.

We noted that care staff understood the importance of promoting equality and diversity. This included arrangements that had been made for people to meet their spiritual needs by attending a religious service.

There were robust arrangements to ensure that people's concerns and complaints were listened and responded to in order to improve the quality of care. Most people told us that they had not needed to make a complaint about the service. However, they were confident that if there was a problem it would be addressed quickly. People's concerns and complaints were encouraged, explored and responded to in good time. Formal complaints were dealt with by the management team, who would contact the complainant and take any necessary action. Complaints were listened to, investigated and managed in line with the provider's policy. People said that they would be confident to make a complaint or raise any concerns if they needed to.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. Records showed that the management team had consulted with people about how they wanted to be supported at the end of their life. This included establishing their wishes about what medical care they wanted to receive and whether they wanted to be admitted to hospital or stay at home.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in July 2017 we rated this key question as 'Inadequate'. We found one breach of regulation. The management of the service had failed to have effective systems and processes in place to monitor and improve the safety of the service provided.

We made a requirement for this to be addressed and the provider sent us an action plan. At this inspection, we found improvements had been made and the regulation was now met. We found although there were significant improvements in the care planning, time was still needed to ensure they were accurate and fully completed. Following inspections of the home, between 2015 to 2018, we have identified variable quality and compliance and examples where "good" quality and safety had not been sustained over time. This demonstrated that the provider's governance and quality monitoring was not always robust or consistent to ensure standards of quality and safety were sustained across their services. Therefore further time and work is needed by the provider to ensure that their systems for monitoring and improving services are embedded and to demonstrate that "good" practice can be sustained at Victoria Hall. Resulting in the rating being changed to 'Requires Improvement'.

We found for two people with diabetes, their care plans lacked clear, comprehensive guidelines with regard to when to seek advice for a blood glucose recording outside of the normal range. We also found one person with a diagnosis of osteoporosis. However their care plan also lacked detail around how this risk was being supported. We found no person to have been impacted by this but was an area requiring improvement. The provider agreed with our findings and provided assurances that everyone's care plans would be reviewed by the end of May 2018. Following the inspection on 4 May 2018 the registered manager submitted these care plans to us, which had been reviewed and as such appeared to now contain sufficient guidance for staff. These care plans had been reviewed, with advice from appropriate healthcare professionals. We will not be able to confirm how these care plans worked in practice until we next inspect the home.

Quality assurance systems were in place that included audits by the registered manager and assistant manager. The audit conducted in April 2018 identified that further work was needed in relation to some people's care plans for specific health needs and also aspects of mental capacity assessment. Action had been taken to ensure mental capacity assessments were completed. The quality assurance team from Norfolk County Council had also been involved between our last inspection to this inspection providing advice and guidance to the registered manager around these areas.

Records showed that the registered manager had regularly checked to make sure that people were reliably benefiting from having all of the care and facilities they needed. These checks included making sure that personal care was being consistently provided in the right way, medicines were being managed correctly and staff had the knowledge and skills they needed. In addition, records showed that fire safety equipment, hoists and kitchen appliances were being checked to make sure that they remained in good working order. The last monthly medication audit in April 2018 identified some staff competency concerns. These issues had been addressed.

One relative told us, "[Registered manager] is approachable. She doesn't fob you off and runs the place well." Another relative told us, "[Registered manager] is understanding and approachable. She's knowledgeable and doesn't judge you. She gives real answers to your questions. When I first visited, looking for somewhere for mum, her caring side came shining through. I turned up without an appointment but she gave me her time. She did not have to spend all that time with me, it must have been almost three hours. I am not leaving my mum with just anyone. [Registered manager] is not office based. [Assistant manager] is great and she can see if I have any concerns. It is in her heart."

We found that the registered manager understood and managed risks and complied with regulatory requirements. Records showed that the registered manager had subscribed to a number of professional websites in order to receive up to date information about legal requirements that related to the running of the service. This included CQC's website that is designed to give providers and registered manager's information about important developments in best practice. This is so they are better able to meet all of the key questions we ask when assessing the quality of the care people receive. Furthermore, we saw that the registered manager had suitably displayed the quality ratings we gave to the service at our last inspection.

Staff were clear about their responsibilities. We noted that each shift was led by a senior member of care staff. These members of staff shared an office and worked closely together. We heard them discussing the personal care needed that day by each person who lived in the service. We then noted that this discussion was reflected in the tasks we saw care staff being asked to complete. In addition, we were present when a senior member of care staff met to hand over information from one shift to the next. We noted the meeting to be well organised so that detailed information could be reviewed in relation to the current care needs of each person.

People who used the service, their relatives and staff were engaged and involved in making improvements. Documents showed that people had been invited to attend joint residents' and relatives' meetings at which they had been supported to suggest ideas about how the service could be improved. However, the majority of relatives had not attended. The registered manager sent newsletters to relatives to keep them up to date with service information, including dates of the next meetings they could attend. We noted a number of examples of suggested improvements being put into effect. An example of this was changes that had been made to the menu so that it better reflected people's changing preferences.

We looked at how the provider formally sought the opinions of people using the service and their families. We noted satisfaction surveys were sent to people and their relatives annually with the last being in April 2018. We noted all expressed a degree of satisfaction, particularly in the areas of staff attitudes and quality of care. Where issues were identified, people and their relatives stated that they were listened to and those issues were resolved in a timely manner.

Care staff told us there was a 'zero tolerance approach' to any member of staff who did not treat people in the right way. As part of this they were confident that they could speak to the registered manager if they had any concerns about people not receiving safe care. They told us they were sure that any concerns they raised would be taken seriously by the registered manager so that action could quickly be taken to keep people safe.

We found that the registered manager had established suitable arrangements to enable the service to learn and innovate. This included members of staff being provided with written policies and procedures that were designed to give them guidance about their respective roles.

Information was available to people and visitors in the hallway of the service. These included the provider's

Statement of Purpose and satisfaction survey forms for people to complete. This facilitated communication channels between people and the service's management.

We found that the service worked in partnership with other agencies. There were a number of examples to confirm that the provider recognised the importance of ensuring that people received 'joined-up' care. One of these involved the provider's membership of a county-wide association that worked to identify how commissioners and service providers could better develop a cross sector approach to delivering high quality care.