Achieve Together Limited

Victoria House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Victoria House is a residential care home that provides personal care and support for up to six people with a learning disability, autism or who have complex needs associated with their mental health. At the time of the inspection there were four people living at the service.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability or autistic people.

People's experience of using this service and what we found.
The provider could not show how they met some of the principles of Right support, right care, right culture. This meant we could not be assured that people who used the service were able to live as full a life as possible and achieve the best possible outcomes.

Although people told us they felt safe living at Victoria House, relatives spoken with said they did not have confidence in the service and did not feel their family members were safe or well looked after.

People were not always protected from the risk of avoidable harm. We found where some risks had been identified, sufficient action had not always been taken to mitigate those risks and keep people safe.

People who had behaviours that could challenge themselves or others had proactive plans in place to reduce the need for restrictive practices. However, some staff had limited knowledge of people's needs or key pieces of information relating to people's care and support. This meant people were not supported to have maximum choice and control of their lives and staff were not supporting people in the least restrictive way possible and in their best interests.

People were not always supported by staff who understood best practice in relation to learning disability and/or autism, as set out in our guidance Right Support, right care, right culture.

There were insufficient numbers of suitably qualified, competent, skilled or experienced staff on duty to meet people's needs safely.

Some areas of the service were not clean, and we were not assured the service was following safe infection prevention and control procedures.

Governance systems did not ensure people were kept safe and received a high quality of care and support in line with their personal needs.

Following the first day of our inspection the provider advised the Commission, relatives and Torbay and Devon County Council of their intention to close the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was Requires improvement (published on 04 February 2021) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection enough improvement had not been made/sustained, and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to the management of risk, staffing levels, staff training and people's personal care needs. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.
We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Victoria House on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so. We have identified breaches in regulation in relation to safe care and treatment, safeguarding people from abuse, staffing, and governance. Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This

means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements. If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We will meet with the provider following this report being published and work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Victoria House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team was made up of one inspector, a medicines inspector and an Expert by Experience who had consent to phone and gain feedback on the care provided by the service from people's relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Victoria House 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 service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The first and second days of the inspection were unannounced.

What we did before the inspection
Before the inspection we reviewed the information we held about the service, including notifications we had received. Notifications are changes, events or incidents the provider is legally required to tell us about within

required timescales. We sought feedback from the local authority.

We used this information to plan the inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spent time with and spoke with three people living at the service, three relatives, three agency and two permanent members of staff, the registered manager. We also spoke with four senior managers who supported the inspection on behalf of the provider. To help us assess and understand how people's care needs were being met we reviewed four people's care records. We also reviewed a number of records relating to the running of the service. These included staff recruitment and training records, medicine records and records associated with the provider's quality assurance systems.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two health care professionals, and representative from Torbay Council's quality assurance and improvement team (QAIT) and three relatives.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

At the previous inspection in December 2020, we found two people were not always supported to have maximum choice and control over their lives. Restrictions had been placed on their liberty to keep them and others safe. At the time of that inspection there was no legal basis or framework in place to support those restrictions. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found not enough improvement had been made and the provider was still in breach of regulation 13.

Following our previous inspection the registered manager had consulted with the local authority and removed all restrictions from one person's care plan. Records for another person showed there continued to be restrictive conditions placed on their care and support. This person was not allowed to leave the service by themselves and there were restrictions in place regarding places they could visit and times. At the time of this inspection there continued to be no legal framework in place to support these restrictions. The registered manager was proactively working with the local authority in seeking a legal solution and continued to provide the Commission with regular updates.
Depriving someone of their liberty for the purpose of receiving care or treatment without lawful authority is a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People told us they liked living at Victoria House as well as the staff who supported them. One person said, "I like living here." Another said, "I'm happy living here and the staff that support me are good." However, three relatives told us they had concerns about safety and had spoken with the local authority, who were looking into those concerns.
• Although people told us they felt safe, they were not protected from the risk of avoidable harm associated with their assessed complex care needs. One person was being monitored for seizure activity and regularly used a hot tub in the garden. At the time of the inspection staff had not been provided with guidance and did not have access to the risk assessment regarding the use of this hot tub. Staff were not able to tell us what action they would take should this person have a seizure whilst using the hot tub. This placed this person at increased risk of avoidable harm.
• People's care files included risk assessments which were based on their support needs. Two members of staff regularly supported people on a one to one basis both, within and outside of the service. They did not know about identified risks as documented in people's individual care plans and risk assessments as they had not had time to fully read them. For example, records for one person showed the manager liaised with the local authority and introduced increased observation of the person in order to reduce/mitigate risks. Some staff we spoke with did not know they needed to provide increased observations or for what purpose.
• People and staff were placed at risk of harm, as staff did not have the appropriate training necessary for

them to undertake their role. Records showed three members of staff had recently been contracted to work at the service via an agency. The registered manager did not know what qualifications or training these staff members had been provided with prior to commencing their shift. This meant they could not be assured these staff members had the experience, skills or competence to meet people's needs safely. This placed people and staff at an increased risk of avoidable harm.
• People were not always protected from risks associated with their environment. Upon arrival at the service we were shown to the main office, where we found the fire door and frame had been removed and there was a large hole in the floor. The registered manager confirmed they had not assessed any of the risks associated with the removal of the fire door or the impact this might have on people living at the service or on staff. The service's fire and environmental risk assessments had not been updated. Senior managers said they had not been made aware that the door had been removed and assured us they would investigate.
• Fire safety records were not up to date and could not be relied upon. For example, staff were recording the office door was missing a sign but failed to record the door had been removed.
• We shared our concerns with Devon and Somerset Fire and Rescue Service and Torbay County Council. Immediate action was taken by the provider to address the concerns. Devon and Somerset Fire and Rescue Service confirmed they were satisfied with the immediate action taken by the service to mitigate fire safety risks.
• A key safe within a communal area of the service containing keys to people's bedrooms, the laundry, boiler room and staff room etc was broken and could be accessed by people, staff and visitors.

The providers failure to ensure they were doing all that was reasonably practicable to manage and mitigate risks placed people at an increased risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

There were insufficient arrangements in place to ensure staff on duty could meet people's needs safely. We found staffing arrangements at night and during the day were not sufficient to meet people's needs safely. The service had recently contracted with an external agency to provide three live-in staff to work at the service. We reviewed the rota and found all three staff had been rostered to work 180 hours and 12 sleep-in shifts over a 14-day period. Long and excessive working hours could impact on the safety of people and staff. Following the inspection, the provider confirmed that they had reduced the hours the agency staff members were working over a seven-day period. The provider assured us that in the event of an agency staff member feeling they were not safe to work or being observed to show signs indicating they needed to take a break from work, the registered manager would intervene.'

The failure to provide sufficient numbers of staff to meet people's care and treatment needs safely, placed people at an increased risk of harm. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection we found the provider failed to ensure that risks relating to infection control were being effectively managed. This was a breach of regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection we found improvements had not been made and the provider was still in breach of regulation 12.

• People were not protected from the risk and spread of infection.
• We were not assured that the provider was doing everything possible to prevent people, visitors and staff from catching and spreading infections. Whilst the provider had in place procedures for visitors entering the service, we found these were not always being followed.
• We were not assured that staff were using PPE effectively and safely. On all three days of the inspection we observed staff members not wearing their masks correctly and asked senior managers to address this.

• We were not assured that the provider was promoting safety in relation to hygiene practices. For example, people's individual living area's and bathrooms were not hygienic. Staff were aware of the need to carry out enhanced cleaning to reduce the risk and spread of infection but told us they didn't have time to do this. Records which showed enhanced cleaning was taking place could not be relied upon as areas identified as being checked were not clean. We discussed what we found with the provider who took immediate action to address our infection and prevention control concerns.

The provider failed to ensure that risks relating to infection control and the transmission of COVID 19 were being effectively managed and this placed people at an increased risk of harm. This was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We were assured that the provider was accessing testing for people using the service and staff.

• On the first day of the inspection we found people's medicines were not being stored safely in accordance with the regulations. On the second day of the inspection, we found the provider had taken action to address this.

The failure to store people's medicines safely was a breach of regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

• Medicines were ordered and disposed of safely and securely.
• Staff were trained to support people to take their medicines safely and were regularly assessed to make sure they were competent.
• Where possible, people were included in medicines reviews and supported to make decisions about their medicines. Accessible information was available to help people understand what their medicines were for and any side effects they might experience.
• People's medicine support needs had been assessed and were recorded in care plans. Trained staff supported people to take their medicines. Where possible, people were included in this process, for example ordering medicines or helping to prepare them prior to administration.
• Staff recorded medicines administration on medicines administration records (MARs). These were an accurate record for most medicines, but we did see that external medicines such as creams and ointments were not always recorded. This had been identified in an audit and a plan was in place to improve staff training and competence in this area.

We recommend the service should continue to improve their medicines processes to make sure people have their creams and ointments applied as prescribed and that this is recorded on medicines administration records.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At the previous two inspections we found systems were either not in place or robust enough to demonstrate the service was being effectively managed. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found not enough improvement had been made and the provider was still in breach of regulation 17.

• Relatives did not have confidence in the service and told us the service was not well led. One relative said, "I have nothing positive to say about them. We are looking to move [person's name] out of Victoria House." Another said, "All I want is for [person's name] to be looked after, cared for, to be understood and do things with them. The last two years have gone from being awful to terrible."
• Whilst management oversight of the service had improved systems and processes designed to monitor the service were not undertaken robustly and could not be relied upon. This meant they were not always effective, did not drive improvement and did not identify the issues we found at this inspection. Issues included concerns with regards to staffing, training, infection prevention and control, fire safety and the management of risk.
• Records were not always accurate or fully completed. Whilst we saw some improvements in people's care records, staff had stopped completing daily handover sheets or checklists. Staff had stopped following the providers established procedures, which were designed to monitor all aspects of the service delivery. When asked, the registered manager had been unaware that staff were no longer completing these records.
• Regular checks of the environment were not sufficiently undertaken to protect people from the risk of harm. We were not assured the service was following safe infection prevention and control procedures. Some areas of the service were not clean, carpets and walls were heavily stained and needed cleaning and we continued to find mouldy/rotten food in people's fridges despite inspectors bringing these concerns to senior staff on all three days of the inspection.
• Poor judgements and decision making in relation to infection prevention and control, fire safety, staffing and the management of risks, potentially placed people at the risk of harm. For example, at the time of the inspection three staff members were living on the premises and working with people on their own. None of these staff had undertaken an induction upon arrival; they did not have sufficient knowledge of the people they were being asked to support and neither the registered nor regional managers were able to tell us what experience, skills or training these staff had completed or any information regarding their vaccination status. We discussed what we found with the registered and senior managers who gave us assurance they would address these concerns immediately. However, following the inspection, we were advised that some of the training did not take place.
• The culture of the service still did not reflect best practice guidance for supporting people with a learning

disability. Staff were not aware of the Right support, right care, right culture guidance published by CQC, or how the underpinning principles could be used to enable people to live an ordinary life, enhanced their expectations, increase their opportunities and value their contributions.
• The provider did not have a good track record on safety and had not demonstrated an ability to learn from past inspections. This was the third consecutive inspection where Victoria House had been rated less than good, and since Achieve Together took over the management of the service.

The provider had failed to ensure the quality and safety of the service had been adequately assessed, monitored or improved to ensure it met with regulatory requirements and best practice guidance. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and deputy recognised the service was not where it needed to be. Senior managers acted upon feedback following the first day of the inspection and advised the Commission, relatives, Torbay and Devon County Council of their intention to close the service.