S.S.Care Limited

S.S Care Limited

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:
S.S Care Limited, hereafter referred to as 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 home and two people being supported in the community as extensive refurbishments were carried out to the basement flats.

People's experience of using this service and what we found
People told us they were happy and felt safe living at Victoria House. We found the service was not operating in accordance with the regulation and best practice guidance. This meant people were at risk of not receiving the care and support that promoted their wellbeing and protected them from harm.

The provider did not have sufficient oversight of the service to ensure people received the care and support they needed that promoted their wellbeing and protected them from harm. Systems and processes to monitor the service were not effective and did not drive improvement. These included concerns with records, risk management, medicines, a lack of person-centred care, infection control and the environment.

The service did not consistently apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

Although the manager and staff demonstrated a strong commitment to the people living in the service and spoke passionately about providing good quality care. They did not always understand how their actions impacted on people's privacy, dignity and/or human rights.

Whilst we did not find people were being disadvantaged, 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.

Staff told us they felt supported and appreciated by the manager. We found the service did not have an effective system in place for recording what training staff had received. This meant that neither the provider or manager could be assured that staff had the necessary skills to carry out their roles.

People told us they could make decisions about what they ate and drank and when and support plans contained clear information about what each person could do for themselves.

Staff who knew people well were familiar with people's different communication methods and how they made their wishes and needs known.

People were encouraged and supported to lead full and active lifestyles, follow their interests, and take part

in social activities

People were encouraged to share their views through regular reviews and relatives felt comfortable raising complaints and were confident these would be acted on.

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

Rating at last inspection
The last rating for this service was good (published 24 May 2017). Since this rating was awarded S.S Care Limited had been purchased by another healthcare provider. Whilst there had been no change to the legal entity there had been a complete change in the senior management of the service. We have used the previous rating to inform our planning and decisions about the rating at this inspection.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches in relation to safe care and treatment, safeguarding people from abuse, the need for consent, dignity and respect, person-centred care, recruitment, training, notifications, and governance. We have also made recommendations in relation to the environment.

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 of 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 to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress and continue to monitor the service through the information we receive until we return to visit as per our re-inspection programme.

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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

S.S Care Limited

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.

Inspection team
The inspection team consisted of one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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 did not have a manager registered with the Care Quality Commission at the time of the inspection. A manager had recently been appointed by the provider to oversee the running of the home and had made an application to register. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered provider, 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.

Notice of inspection:
The inspection took place on the 5, 6 and 8 November 2019, the first day was unannounced

What we did:
Before the inspection we reviewed 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 also asked the provider to complete a Provider Information Return (PIR). The PIR is information we require providers to send us at least once annually to give us some key information about

the service, what the service does well and improvements they plan to make. We used this information to plan the inspection.

During the inspection
We spent time with three people living at the service, five members of staff, the manager who managed the home on a day to day basis and two senior managers. To help us assess and understand how people's care needs were being met we reviewed three people's care records. We also reviewed a number of records relating to the running of the home. 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 quality assurance records and updated copies of the service's improvement plan. We sought views from relatives and asked the local authority who commissions care services from the home for their views on the care and support provided. We received feedback from four health and social care professionals and two relatives. We also contacted South Devon and Torbay NHS Foundation Trust's quality assurance and improvement team (QAIT).

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 good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
• People were not always protected from the risk of abuse, avoidable harm or the use of punitive practices.
• The manager and staff had received training in safeguarding adults and were able to tell us the correct action to take if they suspected people were at risk of avoidable harm or abuse. However, after reviewing people's records and speaking with staff we identified that some people had been placed at the risk of abuse and one person had been subjected to punitive practices, which had not been reported to the local authorities safeguarding team.
• Records for one person indicated staff had failed to recognise that other people not living at the home may have potentially been placed at the risk of abuse or avoidable harm by their actions. We discussed what we found with the manager who told us the risk assessment for this person was inaccurate and misleading. We referred this matter to the local authorities safeguarding team for further follow up and review.
• Incident records for one person showed staff had potentially used non-approved methods to distract and/or restrain this person during incidents. When asked, the manager had been unaware these incidents had taken place. We referred these incidents to the local authorities safeguarding team and asked the service to carry out a review. Following the inspection, the manager confirmed a further 18 incidents had been referred to the local authority for further review.
• People were not always protected from the use of punitive practices. The manager and staff described how they restricted one person's access to the community if they did not do what was expected of them. This person's care and support plan did not provide a clear rational as to why it was necessary to impose these restrictions or provide guidance for staff to follow. When asked, staff were unable to tell us what legal authority they had to impose these restrictions. We found there was no legal basis or framework in place to support these restrictions.
• Records showed accidents and incidents were being recorded. However, we found this information was not being analysed or reviewed. This meant the provider could not be assured that lessons had been learnt or sufficient action had been taken to keep people, staff and others safe from harm. Senior managers gave us assurance moving forward the service would be required to log all information on their established central system which ensured all accident and incident reports were reviewed by the provider to determine if there were any lessons to be learnt.

Whilst we found no evidence that people had been harmed, the failure to protect people from abusive practices and improper treatment and to effectively establish systems to investigate and report allegations of abuse place people at an increased risk of harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection

• People were not always protected from the risk of avoidable harm as risks to people's health, safety and well-being were not being effectively assessed, managed or mitigated.
• Each person had in place a risk management plan. We found in some cases these did not consider all the risk's associated with providing safe care and treatment and we were told by the manager and staff that some of this information could not be relied upon as it was not accurate.
• Some people who experienced behaviours that may place themselves or others at the risk of harm did not have in place detailed positive behavioural support plans and risk assessments to ensure they were supported in line with best practice. For example, we found where physical intervention had been identified within a person's support plan the service did not always have in place a specific care plan or risk assessment to guide staff as to when it would be appropriate to use physical intervention, what type of intervention should be used or how this was to be monitored. This placed people and staff at an increased risk of avoidable harm.
• Where staff were required to work alone with people in the community, the service had not adequately considered the risks of lone working.
• Where some risks had been identified, it was unclear what action had been taken to mitigate those risks and keep people safe. For example, we noted Victoria House had in place a locked door policy as some of the people living at the service would not be safe if they left without support. We found two doors leading to the outside were not locked and had not been fitted with any device that would alert staff if someone left the building unattended. We discussed what we found with the provider and manager who assured us action would be taken in relation to what we had found.
• People were not always protected from the risk of harm as they were living in an environment that may not be safe. At the time of the inspection the provider was having work carried out to the basement of the property. Where construction works are taking place, the provider must have in place adequate arrangements for protecting people, staff and visitors from construction activities.
• We found a suitable and sufficient risk assessment had not been carried out in relation to this work and the site had been left unsecured and was accessible to people, staff and visitors. We brought this to the attention of a senior manager who assured us action would be taken. When we returned on 8 November 2019 we found the site had been secured. We were also provided with a copy of the site risk assessment, however we found this did not consider any risks associated with people living at the home, staff or visitors.
• Fire safety records showed routine checks on fire and premises safety were taking place. However, the provider did not have in place an up to date Fire Risk Assessment, which is a legal requirement under The Fire Safety Order 2005.

Using medicines safely
• People's medicines were not always stored or managed safely.
• We checked the quantities of a sample of medicines against the records and found them to be incorrect. Records were not accurate and could not be relied upon and staff were unable to confirm how much medicine they should have in stock.
• We found medicines were not being stored in accordance with the regulations. We discussed this with a senior manager who arranged for the purchase of a new storage cabinet and gave us assurance this would be properly secured in accordance with the above regulation.
• Staff confirmed they had received training in medicine management, and their competency to administer medicines was being regularly assessed. However, we found the provider was unable to locate evidence of staff competency checks being carried out or when staff last completed medication administration training. The provider explained they were in the process of transferring systems and processes to central training logs which would improve future record keeping.

Preventing and controlling infection
• People were not sufficiently protected against the risk of infection.

• The service was not clean in all areas, carpets were heavily stained, and one person's bedroom/bathroom was not clean, smelt damp and was mouldy. We discussed what we found with the manager who assured us the provider was aware of the concerns and there was a plan in place to address once other work had been carried out. Following the inspection, we were made aware that after best interest discussions between the manager and a healthcare professional the person had been provided with an alternative bathroom to use whilst waiting for his own bathroom to be refurbished. The refurbishment has now been completed.
• There was no evidence to confirm that the service was carrying out infection control audits at the time of the inspection. This meant the provider could not be assured the service was being effectively cleaned and people were protected from the risk of infection.

Whilst we found no evidence that people had been harmed. The provider had failed to ensure all risks to the safety of people receiving care and treatment were appropriately assessed, mitigated or managed. Systems were either not in place or robust enough to demonstrate medicines were managed or stored safely and people were not protected from the risk of or spread of infection. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff confirmed they had access to personal protective equipment (PPE), such as aprons and gloves, to reduce the risk of cross contamination and spread of infection whilst supporting people with personal care or preparing food.

Staffing and recruitment
• Records confirmed a range of checks including references, disclosure and barring checks (DBS) had been requested and obtained prior to new staff commencing work in the service. However, we found some staff regularly came into contact with children as part of their work and the provider did not know if they needed to carry out any additional recruitment checks.
We recommend the provider undertakes a review of recruitment procedures were staff have regular access to children as part of their work.
• The manager told us staff were employed in sufficient numbers to meet people's needs and staffing levels were regularly reviewed.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
• The service did not have an effective system in place for recording what training staff had received. This meant that neither the provider or manager could be assured that staff had the necessary skills to carry out their roles. For example, the manager was unable to tell us if staff had up to date training in medicine administration, safeguarding, mental capacity, physical intervention, autism or fire safety.
• We found staff did not recognise poor practice. For example, in relation to punitive practices or infringing on people's human rights.
• Staff confirmed they attended training however felt some of the courses had been of a poor quality and did not enhance their skills/knowledge. We discussed what we were told with the manager who confirmed the most recent physical intervention, breakaway and de-escalation training was not suitable for the people they supported.
• The manager told us all staff completed an induction and did not work unsupervised until they had been assessed as competent to do so. However, records showed not all staff had completed an induction.
• Staff told us they felt supported and said the manager was always available should they need to speak with them. However, none of the records we saw contained sufficient evidence to demonstrate that staff were receiving regular supervision, annual appraisals or the opportunity to debrief following incidents. We discussed what we found with the manager who explained this had been due to changing roles. However, they had identified this was an area that needed improvement.

Whilst we did not find people had been harmed. The failure to provide staff with appropriate support, training, and supervision necessary for them to undertake their role is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
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 were not always supported to have maximum choice and control of their lives. For example, where the service held or supported some people to manage their finances. There were no mental capacity assessments to show that people did not have capacity to manage their finances or that the decision to hold

their monies had been made in a person's best interests.
• Whilst we saw staff asking people for their consent before providing personal care, we found staff did not have a good understanding of the mental capacity act in practice. This was also evident from people's records.

Whilst we found no evidence that people had been harmed. The failure to assess people's capacity and record best interest decisions risked compromising people's rights. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• We found where some restrictions had been placed on people's liberty to keep them safe, the provider had worked with the local authority to seek authorisation to ensure this was lawful.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support.
• People's needs were assessed before they started using the service to help ensure their expectations and needs could be met. However, we found concerns throughout the inspection that reflected care was not always being provided in line with standards, guidance and regulations. For example, with the use of physical intervention, and the manager told us that people's records had not been regularly reviewed or updated in line with people's changing needs.
• People were encouraged and supported to use a range of healthcare services and staff supported people to attend appointments. Referrals were made to healthcare professionals when needed and people had opportunities to see a dentist, or optician regularly.

Adapting service, design, decoration to meet people's needs
• Victoria House is set over four floors, however at the time of the inspection the basement had been cordoned off due to extensive refurbishment work being carried out. Following a tour of the home we noted that other areas of the home were in need of redecoration and potentially not suitable for the purpose for which they were being used or suitably maintained. We discussed what we found with the manager who explained the provider was aware but given the scale of the current works had needed to prioritise.
• People's rooms were personalised and contained pictures and possessions that were important to them.

We recommend the provider develops and keeps under review a suitable refurbishment plan to ensure the premises are suitable for the purpose for which they are being used and properly maintained.

Supporting people to eat and drink enough to maintain a balanced diet
•Staff told us people were encouraged to be as independent as possible with planning, shopping and cooking their own meals. People told us they could make decisions about what they ate and drank and when. Staff explained how they encouraged and supported people to develop their skills.
•People were encouraged to maintain a balanced, healthy diet. Staff had a good awareness of people's dietary needs and preferences but understood that this was their choice.
•People could help themselves freely to food and snacks throughout the day and night and we saw the kitchen was well stocked with tea, coffee, and soft drinks as well as snacks.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
• People's right to privacy was not always understood by staff or respected.
• We found staff were being asked to act in a way which showed a complete lack of respect for one person's privacy, dignity or human rights. Although staff told us they found the situation uncomfortable they had never challenged the guidance contained within this person's care plan, nor had they received any form of training. We discussed what we found with the manager who gave us assurance they would take immediate action to protect this person's basic human rights with regards to supporting them with intimate relationships.
• On the first day of the inspection, we saw a member of staff accompanied by a person from the supported living service operated by the same provider, had let themselves into the home without knocking or using the doorbell and did not have a valid reason for their visit. Staff on duty did not challenge this person or seemed concerned by their presence. This demonstrated that staff did not see Victoria House as someone's home or have any understanding of how their actions might impact on people's privacy and dignity.
• We discussed what we saw with a senior manager who said they were unaware this was still routinely taking place, as staff had been told they must not access the supported living office via Victoria House.
• Whilst staff understood the importance of confidentiality we found people's personal records were being stored in an unlocked cabinet within a communal area of the home. This meant people's confidential information was not being stored in accordance with the General Data Protection Regulation 2018, (GDPR). We brought this to the attention of the manager.

Whilst we found people had not been harmed, the failure to treat people with dignity and respect is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Support plans contained clear information about what each person could do for themselves. and people were supported to be independent and to develop their skills where possible. For example, we saw staff encouraging people to make their own drinks and meals and to do tasks for themselves.
• People were supported to maintain and develop relationships with those close to them and staff recognised the importance of family and personal relationships.

Ensuring people are well treated and supported; respecting equality and diversity
• People who wished to share their views with us said they were happy living at Victoria House. One person said, "I like living here, I can watch TV or use the PlayStation." Another said, "All the staff are really friendly I like it here. I can come and go as I please."

• People who were not able to communicate with us verbally, looked comfortable with staff and showed in their expressions and behaviours they enjoyed the company of the staff supporting them.
• Staff knew people well and supported people with sensitivity and compassion. Throughout the inspection we saw staff responding to people in a friendly and respectful manner.
• Support plans included information about people's personal, cultural and religious beliefs.
Supporting people to express their views and be involved in making decisions about their care
• People who were able to participate in the planning of their care met with staff to discuss their needs and any changes they wished to make. The manager and staff told us they frequently asked people if they were happy with their care and if there was anything they wanted to discuss or change
• Staff told us people were encouraged to make decisions about day to day matters such as what they wanted to eat, and staff offered people opportunities to spend time, where and how they wished.
• People and those acting on their behalf were provided with a range of opportunities to express their views about the care and support through regular reviews, meetings and surveys.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

• People were at risk of receiving care that did not meet their needs. Each person had an individualised support plan which was linked to a risk management plan. However, we found some people's care records were not written in a person-centred way, contained outdated/ misleading information and could not be relied upon.

• Staff told us they had a good understanding of people's individual needs. However, we found, staff were not always aware of the associated risks as detailed in people's support and risk management plans or that they were infringing on people's human rights.

• Although the manager had started to review people's records they had not identified the concerns we found at this inspection and it was not evident that people's care records were being regularly reviewed prior to the manager starting in August 2019.

Whilst we found people had not been harmed this was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person – centred care.

• People's needs were assessed prior to coming to live at the service. This formed the basis of a support plan, which was further developed after the person moved in and staff had got to know them better.

• Each person's support plan contained important information about people who mattered to them as well as information about people's backgrounds and histories. This gave staff the opportunity to understand a person's past and how it could influence who they were today.

• The service had worked with the local IATT (Intensive Assessment Treatment Team) to develop some people's Positive Behaviour Support plans (PBS) which guided staff on how to support people in managing their own behaviour and/or anxieties in a way, which caused the least amount of distress to the person, or others.

• Records showed some people had signed their support plans and staff told us they had contributed to their development and were aware of their content.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• People had a range of communication needs. Some people due to their disability were not able to

communicate verbally. Staff who knew people well were familiar with people's different communication methods and how they made their wishes and needs known. For example, one person used a very individual form of sign language and communicated through the use of sounds, mood and body language. However, it was noted that people's records did not in all cases include sufficient information about their communication methods or how the service provided/supported people to understand information.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• People were encouraged and supported to lead full and active lifestyles, follow their interests, and take part in social activities. We saw people were encouraged to engage in a wide range of activities based on their individual preferences and interests.
• Each person's support plan included a list of their known interests and staff supported people daily to take part in things they liked to do. For example, going to the cinema, walks, bike rides, playing computer games, going to church, college or going to their girlfriend's house for dinner.
• People were supported and encouraged to maintain relationships with friends and family and we saw during the inspection relatives and most people were able to come and go without any restrictions.

End of life care and support
• All the people living at Victoria House were young adults and did not have life limiting conditions. As such end of life care planning had not been formally discussed with them nor would it have been appropriate to do so. However, each person's support plan contained a health passport which contained detailed information about the person's care and support needs. This helped to ensure people's wishes and needs were respected in an emergency.

Improving care quality in response to complaints or concerns
• One person told us they would speak to the manager or staff if they were unhappy, however not everyone living at the service had the capacity to understand or raise concerns/complaints independently. The manager and staff told us they regularly checked if people were happy with their care by observing body language, meeting and chatting with people informally and getting feedback from others who knew them well.
• Relatives were aware of who they needed to raised concerns with, should they need to do so.
• In the Provider Information Return (PIR), the provider had reported the service had received six complaints in the previous 12 months. The manager confirmed they maintained a record of any complaints received and shared this information with the Care Quality Commission. This showed people's complaints were taken seriously and the home acted upon these to resolve issues.

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 good. 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The service did not have a manager registered with the Care Quality Commission at the time of the inspection. A manager had recently been appointed by the provider to oversee the running of the home and had made an application to register.
- Systems and processes to monitor the service were not undertaken robustly or always completed. This meant they were ineffective, did not drive improvement and did not identify the issues we found at this inspection. These included concerns with regards to care planning, risk management, infection control and the management of people's medicines.
- The registered provider did not demonstrate they had sufficient oversight of the service to ensure people received the care and support they needed that promoted their wellbeing and protected them from harm.
- People were not always protected from the risk of abuse, avoidable harm or the use of punitive practices and systems were not in place to ensure the manager and/or provider was made aware of all incidents. This meant they could not be assured that appropriate action had been taken to safeguard people or reduce the risk of reoccurrence.
- The home did not have effective systems in place to assess or to monitor staff competence and skills to carry out the role required of them. This meant the provider could not be assured staff had the necessary skills and knowledge to meet people's assessed needs in a safe way.
- People were not protected from the risk of harm as they were living in an environment that may not be safe. Whilst some premises checks had been completed, risks to people's health and wellbeing had not always been identified, assessed or mitigated.
- Records were not accurate, complete or stored securely.
- At the time of the inspection the provider told us they were providing care and support to people not currently residing at Victoria House due to extensive basement refurbishment works. This meant there was a potential breach of a condition of registration which has since been resolved.

Whilst we did not find people had been harmed the failure to operate effective systems and processes to assess, monitor and improve the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•The registered provider was aware of their responsibilities in relation to duty of candour, that is, their duty to be honest and open about any accident or incident that had caused or placed a person at risk of harm

and/or events which prevents the provider from carrying out a regulated activity safely. However, we found the provider had not notified the Care Quality Commission of significant events, which had occurred in line with their legal responsibilities. This included the notification of safeguarding concerns as well as damage to the premises which affected the running of the service.
Whilst we did not find people had been harmed, this was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (part 4).

• We discussed what we found with senior managers who acknowledged that some concerns had been a direct result of the acquisition of S.S Care Limited in March 2019 in that Victoria House had not fully been integrated into their established governance systems which would have identified the concerns we found.
• Throughout the inspection we found senior managers were open, transparent and responsive to our feedback and demonstrated a good understanding of the improvements needed. We saw evidence that the provider's regional manager had undertaken audits and put in place a service improvement plan and whilst they had not been aware of all the concerns we identified they were aware of the need to improve.
• Following the inspection, managers continued to make improvements, they developed an action plan and shared the initial inspection feedback with people's families where appropriate, commissioners and care managers.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics: Working in partnership with others: Continuous learning and improving care
• We received mixed views about the overall management of the service. Senior managers described the various actions they had taken as a new provider to engage and support staff, people and families through the acquisition and transition process. However, staff and relatives felt that communication with the new providers had been poor and the new manager had been left to get on with it. A healthcare professional said, "I think standards have slipped."
• The manager told us their vision for the home was to create a safe and supportive environment that aims to empower people to take responsibility for managing their own behaviours and move towards independent living.
• Staff spoke passionately about their work and the people they supported and were proud of people's achievements and described the new manager as open, honest and approachable.
• There were a variety of ways in which people could give feedback. These included annual surveys, residents' meetings, care reviews and through the complaints process.
• The service had developed working relationships with other health and social care professionals which meant advice and support could be accessed as required.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered manager had not notified the CQC of significant events in line with their legal responsibilities. Regulation 18 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care and treatment was not appropriate, did not meet their needs, or reflect their preferences. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. People's right to privacy was not always respected or understood by staff. Regulation 10 (1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent

The provider had not acted in accordance with the principles of the Mental Capacity Act 2005.

Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were exposed to the risk of harm as care and treatment was not always provided in a safe way. Risks to people's health and safety had not been identified or mitigated. Medicines were not always stored securely. Regulation 12(1)(2)(a)(b)(c)(d)(g)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes had not been established or operated effectively to investigate immediately upon becoming aware of any allegation or evidence of abuse. Care and treatment was provided in a way, which intended to control a person's behaviour which was not proportionate to the risk of harm. Regulation 13 (1)(3)(4)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to assess, monitor and improve the safety and quality of the service.

	The provider had failed to maintain accurate, complete and contemporaneous records for each person living in the home. Regulation 17 (1)(2)(a)(b)(c)(f)
Regulated activity	**Regulation**
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured staff received the necessary skills required to carry out their duties. Regulation 18 (1)(2)(a)(b)