The Regard Partnership Limited

Victoria House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

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 six people living at the service.

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 whilst the service had made a number of improvements following the last inspection the service was not operating in accordance with the regulations and best practice guidance. This meant people were at risk of not receiving care and support that promoted their wellbeing and protected them from harm.

Quality assurance and governance systems were in place to assess, monitor, and improve the quality and safety of the services provided. However, we found the systems in place had been ineffective in identifying some elements of poor practice. For example, people were not always protected from the risk of avoidable harm. We found risks, such as those associated with the environment, had not been managed safely or within a timely manner.

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 providing support to people with a learning disability and/or autistic people.

The service was not fully able to demonstrate how they were meeting the underpinning principles of right support, right care, right culture. The culture within the service did not always promote a positive and person-centred culture. This meant we could not be assured that people who use the service were able to live as full a life as possible and achieve the best possible outcomes that include control, choice and independence or that they were being supported to be the best version of themselves.

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.

People were not always protected from the risk and spread of infection. We were not assured the arrangements in place to ensure the service was kept clean were sufficiently robust to control and prevent the spread of infection.

People's medicines were managed safely. However, where people had been prescribed medicines they only needed to take occasionally, guidance for staff was not always provided. We have made a recommendation in relation to medicines.

Risks such as those associated with people's complex mental, physical and/or health needs had been

assessed and were being managed safely.

Staff were recruited safely and there were sufficient numbers of staff deployed to meet people's needs.

People were encouraged to share their views through regular house meetings and relatives felt able to raise concerns, although we received mixed feedback about how the service responded to concerns raised with them.

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 Inadequate (published on 28 January 2020) 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.

This service has been in Special Measures since January 2020. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected □
This was a planned inspection based on the previous rating and part prompted by concerns reported by the service in relation to people's safety. A decision was made for us to inspect and examine those risks. 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 coronavirus 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 inadequate to requires improvement. 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 relation to safe care and treatment, safeguarding people from abuse, and governance at this inspection.

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.

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below

Is the service well-led?

Requires Improvement

The service was not always 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 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 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. There was also a manager in day to day charge who had worked for the service for a short period of time. We refer to them as 'the manager' throughout the report.

Notice of inspection
The inspection took place on 04 December 2020, and 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 used all 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 spoke with two people living at the home, three staff members, the registered and regional managers. To help us assess and understand how people's care needs were being met we reviewed four people's care records and observed staff interacting with people. We also reviewed a number of records relating to the running of the service. These included infection control, medication, environmental safety, staff training, 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 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 two relatives and two healthcare professionals.

Requires Improvement

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 inadequate. At this inspection this key question has improved to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse
At our last inspection we found people were not always protected from the risk of abuse, avoidable harm or the use of punitive practices. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, whilst we found improvements had been made and action had been taken in relation to the specific concerns identified at the previous inspection, the provider was still in breach of regulation 13.

• People were not always protected from the risk of abuse. Records for one person showed that following an allegation by another person living at the service; the manager liaised with the local authority and introduced increased observation of the person in order to reduce/mitigate risks to other people living at the service. Records showed these checks were not being consistently recorded by staff. We found some days there were no daily records for this person. When asked the registered manager was unaware that staff were not following the guidance provided and was not able to provide assurance that these checks were taking place.
• People were not always supported to have maximum choice and control of their lives. Records for two people living at the service showed there were various restrictions in place, which placed restrictive conditions on their care and support. For example, being able to leave the service by themselves, places they could visit, access to the internet and/or having to hand in their mobile phone. There were no records to show the rational for these decisions, or whether this was being carried out in their best interests. We discussed what we found with the registered manager who told us that some restrictions had been placed on people's liberty to keep them and others safe and that they had discussed the restrictions with the local authority. We found there was no legal basis or framework in place to support these restrictions.

Whilst we found no evidence that people had been harmed, the failure to protect people from abuse and depriving someone of their liberty for the purpose of receiving care or treatment without lawful authority is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People told us they felt safe living at Victoria house. One person said, "I do feel safe here." Another said, "I like living here and the staff are really good." However, we received mixed feedback from relatives in relation to people's safety. One relative said, "I believe [person's name] is safe living there and the staff are good with [person's name]." However, another relative said, "I do have some concerns about [person's name] safety, [person's name] does not like living there anymore." We have discussed our concerns with the manager and local authority.
• Policies in relation to safeguarding and whistleblowing were in place and staff had received training based

upon these.
• The registered manager was aware of their responsibility to liaise with the local authority about safeguarding issues. Where concerns had been raised, we saw these had been reported appropriately to the local authority.

Preventing and controlling infection
• People were not always protected from the risk and spread of infection.
• Best practice guidance was not always followed in relation to infection control. For example, we observed one staff member wearing their face mask below their nose.
• We were not assured that the provider was doing everything possible to prevent visitors from catching and spreading infections. For example, staff did not ensure visitors were given clear instructions in relation to the services' infection control procedures. Visitors were not always prompted/directed to wash their hands or use hand gel. Whilst the service had in place clear procedures for screening visitors for symptoms of acute respiratory infection entering the service, this process was not always followed by all staff.
• We were not assured that the providers arrangements for donning and doffing personal protective equipment (PPE) were sufficient to prevent cross-contamination.
• We were not assured the provider was promoting safety through the services hygiene practices as the arrangements in place to ensure the service was kept clean and hygienic to reduce the risk of transmission, were not sufficiently robust to control and prevent the spread of infection.
• Individual risk assessments had failed to identify service users and staff who might be at higher risk from COVID-19. For example, whilst individual risk assessments had been completed these had failed to identify service users and/or staff who were at higher risk or in a vulnerable group because of their ethnicity.
• People were not always supported or encouraged to socially distance whilst in communal areas of the home. Seating arrangements in some communal areas did not enable people to maintain the minimum distance from each other when sitting down, which placed people at greater risk from the spread of Covid19.

• The service did have policies and procedures in place to assist staff in the management of COVID-19. However, we found these were not always being adhere to by all staff entering and leaving the building.

Whilst we found no evidence that people had been harmed. The provider had failed to ensure that risks relating to infection control were being effectively managed and this placed people at increased risk of harm. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We shared our concerns with the local authority.

Following the inspection, the provider wrote to us and confirmed action had been taken to address concerns relating to infection prevention and control.

Assessing risk, safety monitoring and management
At our last inspection we found 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. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection whilst we found improvements had been made and the provider was no longer in breach of regulation 12, however, some improvements were still needed.

• At the last inspection we found 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. We reviewed the home's fire safety precautions. Records showed a fire risk assessment had been completed in September 2020, which identified several actions/recommendations which needed to be completed within a specified time frame. We noted a number of actions were still outstanding. For example, there continued to be gaps in fire testing records and

some fire doors and closures still needed to be replaced. We discussed what we found with the manager who assured us that staff had been reminded of the importance of completing fire safety testing records and showed us a quote for the necessary works to be completed.

We recommend the provider review the requirements of the fire risk assessment to ensure that all works are/or have been carried out within the specified time scales.

• People were protected from the risk of harm. Risks such as those associated with people's complex mental, physical and/or health needs had been assessed and were being managed safely. Each person had a risk management plan in place which was linked to their support plan. Risk management plans described what needed to happen to keep people safe and were being reviewed. Staff were aware of people's individual risks, potential triggers and signs that might show the person was becoming unwell or in need of support. However, we noted where required it was not evident these documents had been signed by all staff to confirm they had been read and understood.
• At the previous inspection we found people, staff and visitors were potentially placed at risk as the provider had not considered all the risks associated with construction work taking place at the property. At this inspection we found construction works have been completed.

Using medicines safely
At our last inspection we found people's medicines were not being managed or stored safely. This was a breach of regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection whilst we found improvements had been made and the provider was no longer in breach of regulation 12, however, some improvements were still needed, and we have made a recommendation.

• Medicines were managed and stored safely.
• There were systems in place to audit medication practices and clear records were kept showing when medicines had been administered or refused.
• Staff confirmed they had received training in the safe administration of medicines and records showed staff were having their competency assessed.
• One person had been prescribed variable dose medicines they only needed to take occasionally, for the management of pain. Records did not always contain clear guidance for staff as to when these medicines should be used. Whilst we did not find this person had not received their medicines as prescribed, this information is necessary as it provides staff with information to help ensure those medicines are administered in a consistent way.
• Records for two other people living at the service also indicated that they were prescribed variable dose medicines. Clear guidance for staff as to when these medicines should be used had not been provided, however the registered manager advised us that these records were inaccurate.

We recommend the provider undertake a review of the systems in place to manage variable dose medicine to incorporate current best practice guidelines.

Staffing and recruitment
At the last inspection we recommended that the provider undertook a review of recruitment procedures were staff have regular access to children as part of their work. Following that inspection, the provider confirmed that a review had taken place and clear guidelines for staff had been introduced.

• People were protected by safe recruitment processes.
• Systems were in place to ensure staff were recruited safely and were suitable to support people who might potentially be vulnerable by their circumstances. 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.
• Staff were employed in sufficient numbers to meet people's needs. People, staff and relatives felt there were enough staff on duty to support people and keep them safe. The registered manager told us staffing levels were organised around each person's specific support needs and where people had been identified as needing additional support this was provided.

Learning lessons when things go wrong
• All accident and incidents were recorded and reviewed by the registered manager to determine if there were any lessons to be learnt and shared with staff to prevent re-occurrences.

Requires Improvement

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 inadequate. At this inspection this key question has now improved to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred 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

At the previous inspection in November 2019, we found the provider had failed to operate effective systems and processes to ensure compliance with the regulations. This was a breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection whilst we found improvements had been made, the provider was still in breach of regulation 17.

• Following the previous inspection, the provider had introduced a range of internal and external quality assurance processes such as audits, regular reviews and spot checks to help ensure the registered manager had the information they needed to monitor the safety and quality of the care provided. Whilst these quality assurance systems had addressed many of the concerns we had previously found, they had not identified all the issues found at this inspection nor had they been instrumental in driving improvement in a timely way. For example, in relation to people's medicines, infection control, fire safety, building maintenance and record keeping.
• The registered manager 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.
• Whilst the management and staff structure provided clear lines of accountability and staff were clear about their role and what was expected of them; we found staff did not always follow guidance provided in relation to safeguarding people from abuse, infection control and/or completing daily records. When asked neither the registered manager or manager had been aware that staff were not following the guidance provided. For example, the registered manager had introduced a new comprehensive daily handover sheet which was to be completed daily by senior staff on duty. We found this checklist had not been completed since September 2020 and staff were continuing to use old paperwork.
• The culture within the service did not ensure that people were supported to have maximum choice or control over their lives. Whilst the registered manager and staff had received training, they did not always recognise restrictive practices.
• Regular checks of the environment and the maintenance and safety of equipment had not been sufficiently undertaken to protect people from the risk of harm.
• We were not assured the service was following safe infection prevention and control procedures to keep people safe. For example, we found some areas of the service were not clean, carpets were stained, and

walls needed painting.
• We discussed what we found with senior managers who told us that whilst significant improvements had been made, improvements in the culture of the service still needed to be embedded and sustained.

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

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• At the last inspection we found the provider had not notified the Care Quality Commission of significant events, which had occurred in line with their legal responsibilities. At this inspection we found the registered manager was aware of their responsibilities under the 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 as well as the regulatory requirement to provide CQC with important information.

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
• The registered manager met regularly with other senior managers within the group virtually, this enabled them to share ideas and keep up to date with changes in practice.
• People, and those important to them, had opportunities to feedback their views about the quality of the service they received. One person said, "We have regular house meetings where we are able to talk about anything, but if I need to talk to [Manager name] I just have to ask." However, relatives told us they had not been encouraged to provide any formal feedback or kept up to date with any changes following the last inspection. One relative said, "I have not seen the previous report, and no one has discussed this with us." Another said, "We haven't been asked for feedback and no one has spoken to us about any changes they have made."
• The registered manager told us they had an 'open door' approach, meaning staff could raise any issues or questions at any time and daily handovers took place to ensure important information was shared.
• Learning had taken place from accidents and incidents. The registered manager told us that concerns and complaints were listened to and acted upon to help improve the service. However, we received mixed feedback from relatives. One relative felt the service had responded to their concerns promptly, but another did not. One relative said, "Whenever we have raised a concern this has always been dealt with promptly and the staff that work with [person's name] are excellent." Another said, "We do not always feel listened to, things are getting better with the new manager but only time will tell."
• The registered manager had developed positive working relationships with other health and social care professionals which meant advice and support could be accessed as required.
• The service was working in partnership with other organisations to support care provision and service development. Following the previous inspection, the service continued to liaise with South Devon and Torbay NHS Foundation Trust's quality assurance and improvement team (QAIT).
• The provider responded promptly to address any issues raised at this inspection. For example, in relation to infection prevention and control as well as seeking advice in relation to restrictive practices.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes had not been established or operated to effectively protect service users from abuse. The provider had failed to ensure people were not being deprived of their liberty for the purpose of receiving care or treatment without lawful authority Regulation 13 (1)(2)(3)(5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems and processes to ensure compliance with the regulations. 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)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure service users, staff and visitors were protected from the risks of infection and best practice was not always followed in relation to infection control which placed people at an increased risk of harm. Regulation 12, (1)(2)(a)(b)(h)

The enforcement action we took:

On the 10th December 2020, the Care Quality Commission served a warning notice under Section 29 of the Health and Social Care Act 2008 for failing to comply with Regulation 12, (1)(2)(a)(b)(h), Safe care and treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was required to become compliant with Regulation 12, section (1)(2)(a)(b)(h), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 above by 18 December 2020.