Precious Homes Limited

Precious Homes Wembley

Inspection report

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Wembley
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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Precious Homes Wembley is a supported living service for people with a learning disability or autistic spectrum disorder. It provides personal care for people who live in their own accommodation from three locations, Verney Street, Sanderling Place and 75 The Avenue. At the time of the inspection one person was receiving care at Verney Street, two at Sanderling Place and four at 75 The Avenue.

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 Care Quality Commission (CQC) follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

This was a targeted inspection and our focus and judgement in relation to Right support, right care, right culture was limited to the use of restraint and consistency in staffing. We have judged that, in as much as the provider had made progress there was still some work to be accomplished and further embedding of systems and processes to meet the underpinning principles of Right support, right care, right culture.

We received information about the use of inappropriate restraint. Therefore, we inspected the service to see current usage of restrictive practices, such as physical restraint, seclusion and as required medicines. Seclusion is the supervised confinement of an individual receiving care in a room, which may be locked, to protect the person and others from significant harm. We observed the provider adopted a least restrictive approach in supporting people whose behaviours posed challenges to services.

However, there was still some work in progress relating to creating a consistent and predictable environment for people. Generally, people with autism spectrum disorders and related needs find it difficult to cope with change. We found evidence people had not benefitted from a stable and consistent environment, including receiving care from regular staff for a significant period prior to this inspection. At this inspection we saw evidence the provider had begun taking action to address that. We made a recommendation about an effective recruitment and retention strategy.

Although there was a system for learning lessons from incidents, we judged this was underutilised. We found the system did not ensure underlying as well as immediate causes of accidents and incidents were understood, taking full account of organisational factors. We have made a recommendation about this.

In the final analysis, we were satisfied that there was a minimum use of physical restraint. Physical restraint had been used on one person since January 2021. The person was no longer receiving care from the provider. During the inspection we observed staff using effective reactive strategies, including distraction and de-escalation to minimise use of restrictive interventions. Furthermore, the provider had put in place interim measures to minimise further use of physical restraint. Therefore, although more improvements

were required, the provider had responded promptly to make people safe by reducing the use of physical restraint.

Rating at last inspection
The last rating for this service was Requires Improvement (published 8 March 2021).

Why we inspected
We undertook this targeted inspection to follow up on specific concerns about the use of inappropriate restraint at the service. A decision was made for us to inspect and examine those risks.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question. We found no evidence during this inspection that people were at risk of harm from these concerns.

Follow up
We will continue to monitor information we receive about the service until we 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?

Inspected but not rated

Inspected but not rated.

At our last inspection we rated this key question Requires Improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question, we had specific concerns about.

Is the service effective?

Inspected but not rated

Inspected but not rated.

At our last inspection we rated this key question Requires Improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question, we had specific concerns about

Is the service well-led?

Inspected but not rated

Inspected but not rated.

At our last inspection we rated this key question Requires Improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question, we had specific concerns about

Precious Homes Wembley

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check whether the provider had met the requirements of the specific concern we had about the use of physical interventions.

Inspection team
This inspection was undertaken by two inspectors, one specialist advisor and two Experts by Experience, who phoned 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
Precious Homes Wembley provides care and support to people living in a 'supported living' setting, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

The service did not have a manager registered with the Care Quality Commission.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We had requested information from the provider prior to the inspection and this information was used as part of the inspection plan. 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 seven members of staff including the new manager and the operation manager. We contacted relatives of people receiving care. We were not able to speak to people due to their needs, but we observed care to help us understand the experience of people who could not talk with us. We reviewed a range of records. This included six people's medicines records, five protocols for medicines to be taken 'when required' and behavioural support plans. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the parts of the key question, we had specific concerns about. The targeted inspection was in response to safeguarding risks raised by the local authority around the use of inappropriate restraint and to check people's safety. We will assess all the key questions at the next comprehensive inspection of the service.

Assessing risk, safety monitoring and management

• We found no evidence that inappropriate restraint was being used at the time of this inspection. Restrictive practices such as MAPA (Management of Actual and Potential Aggression), were not in use because people receiving care at the time of this inspection responded to proactive strategies, which meant the provider was being successful in using least restrictive options.

• However, the provider had not maintained a safe, predictable and stable environment to implement a positive behavioural support (PBS) approach, for some months prior to this inspection. PBS is based on an understanding that behaviours that challenge serve important functions for those who display them. Therefore, a functional analysis, considering environmental triggers and reinforcing consequences is undertaken as the basis for interventions.

• High staff turnover and a lack of compatibility between some people receiving care had affected the delivery of care. Between January 2020 and April 2021, 43 employees had resigned, with as many joining the organisation. Furthermore, since September 2020, three people receiving care at Verney Street had their placements terminated prematurely because they were not compatible with other people using the service and the provider could no longer meet their needs.

• The contributions of the care environment in sustaining behaviours that challenged were highlighted in the multi-disciplinary (MDT) meetings. This was also a recurring theme in our interviews with some health care professionals and relatives of people.

• A health care professional shared a comment about the wellbeing of a person receiving care, "[Their] behaviours appear to be triggered by changes around [them]. Therefore, behaviour and mental state deteriorated frequently last year due to changes within the home. Starting with a new person who was [not compatible] but the main change was lack of manager since January 2020."

• The value of a safe, consistent and predictable environment in supporting people with autism spectrum disorders (ASD) and those who display behaviours that challenged was also acknowledged in the provider's own brochure, "Consistency of support and approaches is key within our teams." However, by all accounts, this had not been the case during some months prior to this inspection.

• That said, at this inspection we saw people had risk assessments relating to their health, safety and welfare. Records confirmed people with behaviours that challenged had a recent holistic assessment and an individualised behaviour support plan.

• During the inspection we observed the use of PBS approaches, both proactive and reactive. We observed staff using effective reactive strategies, including distraction and de-escalation to minimise use of restrictive interventions.

• There was evidence the provider had begun taking steps to create a stable environment for PBS. However, this was still work in progress.

Learning lessons when things go wrong
• The accident/incident system was not utilised effectively to ensure the reported incidents ultimately led to meaningful changes.
• All incidents of physical interventions were reported, and staff received post incident support, and there was evidence of post incident analysis so safety could be improved.
• However, there were gaps in the content and format of information that was reported, which meant the analysis was limited. The analysis focussed on front-end failures that led to incidents rather than other parts of the system. For example, there was more focus on individual staff than other environmental factors such as staffing gaps.
• We evaluated incident reports relating to one person and their subsequent analysis. This considered all incidents from January 2020 to April 2021. The analysis focussed on immediate causes rather than other influences including environmental factors such as staffing, skill mix and workload. In failing to do so, the chain of events that led to an incident were not fully considered.
• We found that following our inspection the provider had taken some action to improve the care of people. However, there is a risk these interventions are tokenistic if pre-existing organisational factors that set up the conditions for accidents and incidents to occur are not fully addressed. The provider is reviewing their system of deriving lessons from accidents/incidents.

Staffing and recruitment
• The provider had not always deployed staff with the right skills, abilities and experience to support people. The service had experienced a high staff turnover in the past 12 months.
• People's relatives described the impact of staff turnover. Their comments included, "Staff are constantly changing and not trained to deal with violent behaviours", "There are frequent changes of staff. There is no continuity of care" and "Information about [people receiving care] is not shared. The high turnover of staff means messages are not passed on."
• However, at this inspection we saw that the service had recruited, with all posts filled. A new manager had also been recruited.
We recommend the provider seek advice and guidance from a reputable source, regarding developing an effective recruitment and retention strategy.

Medicines
• Medicines were administered safely. A policy for medicines management was in place and available for staff members to refer to. However, the provider operated two systems in parallel, a paper and electronic system. We discussed with the operations manager whether this could be simplified to make it easier for staff to follow. However, all medicines were available for all people and recorded as administered.
• All staff members had undergone the relevant training for medicines administration as per the provider's policy.
• Particular attention was paid to the use of when required (PRN) psychotropic medicines for agitation, anxiety, distress or to promote sleep. This was important as it demonstrated good practice in the context of a PBS approach, meaning medicines to reduce levels of agitation during periods of distress, was not used more than was therapeutically necessary.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the parts of the key question, we had specific concerns about. The targeted inspection was in response to safeguarding risks raised by the local authority around the use of inappropriate restraint and to check people's safety. We will assess all the key question at the next comprehensive inspection of the service.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.
• The provider used a PBS approach as a model for supporting people with behaviours that challenged the service.
• There were functional assessments and their analysis had been carried out. Based on the findings, there were proactive strategies that sought to reduce the likelihood of behaviours of concern occurring, and reactive strategies, including MAPA, which aimed to reduce the risk of harm to the person and others, where a behaviour of concern could not be prevented.
• We saw from the provider's brochure, it prides itself in "Using positive risk management approaches, which equips individuals to self-manage their lives and increase skills within a supportive environment, where choice and control are embedded into everyday practice." Whilst we saw evidence of this during the inspection, this had not always been the case.
• As already noted, prior to this inspection there was evidence people had not benefited from a stable and consistent environment. The provider's failure to recruit and retain the right staff, had meant PBS could not always be delivered in line with standards. Commenting on the implementation of a visual timetable, a health care professional said, "The now/next system did not seem to have been used for several months." Furthermore, the frequent changes of managers meant there was less regular input to monitor if staff understood PBS strategies and protocols through observation of practice.
• Therefore, we have judged that, in as much as the provider had demonstrated progress in the application of PBS standards during this inspection, there was still some work to be accomplished, particularly in maintaining a stable and predictable environment as this was key to delivering effective PBS.

Staff support: induction, training, skills and experience
• Staff received essential training to enable them to carry out their duties. We saw from records they had completed autism awareness, learning disabilities, MAPA foundation and advanced courses and mental health. Staff had also acquired other competencies through PBS workshops and reflective practice.
• However, the high turnover of managers meant they had not been well supervised to fulfil their roles effectively. Although the service employed a knowledgeable operations manager, their workload was increased by the high turnover of managers.
• Relatives described staff training as not sufficient. Commenting on staff competence, a relative told us, "Staff lock themselves in office rather than employing useful strategies to manage." We confirmed there was an incident, when a member of staff locked themselves in an office to avoid a physical attack by a person

receiving care.
• However, since the recruitment of the new manager staff have been receiving regular bi-monthly supervisions and unscheduled meetings with managers. Staff told us there was now more input from managers.

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 can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

• Staff completed training to help them understand the principles of the MCA. They understood the importance of gaining people's consent before providing care and support and promoting people's rights and choices.
• There was evidence relevant legislation was understood by staff and was implemented appropriately. People, and where necessary, their families were involved in mental capacity assessments and best interests' decisions.
• The provider monitored and reviewed use of restrictive practices through their accident/incident reporting system. However, as stated we found shortfalls with the system. The reporting system did not cover all restrictive practices including PRN medicines and seclusion.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the parts of the key question, we had specific concerns about. The targeted inspection was in response to safeguarding risks raised by the local authority around the use of inappropriate restraint and to check people's safety.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people.
• The provider had not always provided person-centred care in supporting people who displayed behaviours that challenged. Professionals and relatives spoken with linked this to a variable workforce. A health care professional said, "The lack of consistency may have been largely due to a high turnover of management and staff which made it challenging, to implement the strategies provided." A relative told us, "There are frequent changes of staff and managers, which means there is no consistency or continuity of care."
• Although we evidenced practices that were values led, including a PBS approach, ultimately, staff are a key resource in providing person-centred care, and as noted the provider had relied on a variable workforce, which meant the environment had not always been stable and consistent for people. For example, the mental state and behaviour of one person deteriorated frequently in the past year before their placement was eventually terminated. A health care professional told us this was due to changes in the person's environment.
• Evidence showed behavioural interventions had not always delivered desired outcomes for some people who displayed behaviours that challenged. In some examples, this had led to early termination of placements.
• Whilst we saw evidence the provider had acted, with most vacant posts filled, the ability to retain the right people with the right skills was key to creating a person-centred culture and an environment that was empowering to staff and people receiving care. Therefore, even though the provider had recruited into all vacant posts, we will continue to monitor how the provider develops and retains its workforce.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;
• The structure of the service at the time of the inspection did not offer a supportive environment for managers and staff to fully demonstrate competencies required to deliver effective PBS. It was almost impossible on practical terms for managers to have a regular presence in care environments. The three services had one manager, when one was in post. The significant demands on the manager from all three supported living services was not conducive to effective and responsive management of them. There was an operations manager we found to be knowledgeable, but she oversaw eight services.
• Often, there was no regular manager to implement managerial competencies required to facilitate a PBS approach, including supporting staff and input from specialist teams.
• Whilst staff received bi-monthly supervisions, de-briefings and attended meetings, this was not sufficient

support for staff working in PBS environments. The provider had lost a total of 43 staff in the last 12 months. There was no active leadership, which could have provided regular observations, instant verbal and written feedback to enhance consistency in PBS implementation. Staff may also have missed learning opportunities that could have been provided by a manager leading and modelling the implementation of PBS in practice.
• Although the provider worked in partnership with members of the MDT, the implementation of PBS strategies, including behavioural support plans, visual timetables and activities, required regular presence of managers to lead and coordinate.
• Following the inspection, the operations manager contacted and told us that the provider was redesigning the management structure of the three services. Since the inspection there are now two managers, with one overseeing two services. Additionally, there are three deputy managers, with one on each site.

Continuous learning and improving care
• There were weaknesses in the provider's learning lessons process. The system focussed more on immediate than underlying causes. Even though the provider had taken immediate action to mitigate risks following a serious incident at one of the services, this did not address underlying causes.
• There were gaps in the way the service analysed incident information. Incidents were analysed in isolation as separate incidents and not in groups of accidents. As a result, the analysis did not identify underlying causes, themes and trends. For example, the premature termination of care of three people who displayed behaviours that challenged suggested issues with staffing and the provider's admissions procedures, including compatibility issues between people receiving care. However, these themes were not apparent in findings.
• The leadership's response to the challenges of retaining skilled staff particularly in areas of the service which were hard to recruit to was not sufficient. Although the provider had recruited 46 staff after losing as many, the approach was rather reactive than a well thought out strategic undertaking, based on a comprehensive recruitment and retention strategy, with clearly stated actions to mitigate the risk of losing staff.
• Some staff who left had reported low wages, lack of career advancement opportunities, less satisfaction with the job and burnout. These were predictors of staff turnover, but there was no robust process of analysis in order to develop evidence driven solutions to limit the pace at which staff were resigning early, particularly staff supporting people who displayed behaviours that challenged.
• Therefore, we have judged that, in as much as the provider had acted to address shortfalls, some of these had been identified through anecdotal evidence or through comments by other stakeholders as opposed to an effective system of continuous learning and improvements.

We recommend the provider seek advice and guidance from a reputable source, about the management of and learning from accidents and incidents.