Precious Homes Limited

Precious Homes Hertfordshire

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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

About the service
Precious Homes Hertfordshire is a service providing supported living for people living with a learning disability, autism, mental health needs and sensory impairments. The service can support up to 15 people. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. At the time of the inspection 10 people were being supported with personal care.

People's experience of using this service and what we found

Right Support
The provider had failed to ensure people's care plans reflect up to date information and detailing long-term aspirations.

People were supported by staff who had not had adequate inductions, training and skills to support them.

The management team did not ensure people's medicines were managed in a safe way.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Right Care
People were not always supported by a service that had effective systems in place to report and respond to accidents and incidents. Staff did not always understand how to protect people from poor care and abuse. Staff had training on how to recognise and report abuse, however staff actions did not always show they understood this.

Some people said they did not feel safe with the support they received.

Right Culture
People did not always have assessments in place, to identify risks people faced and how staff should manage these. When risks to people were identified actions to mitigate these were not resolved in a timely

manner which put people at risk of harm. Staff were not always knowledgeable about the content of these risk assessments.

People were not supported by staff who understood best practice in relation to supporting people.

The service had a number of changes in management. Relatives and people stated they did not feel the service was well managed. Staff acknowledged there had been changes in management and gave mixed views about how they felt supported.

People's quality of support was not enhanced by the quality assurance system the provider had in place. Actions were not documented, and it was unclear if actions were completed. This had an impact on people's care.

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 June 2022). At this inspection we found the provider remained in breach of regulations. This service has been in Special Measures since June 2022. During this inspection the provider did not demonstrate that improvements had been made. Therefore, this service remains in Special Measures.

Why we inspected
We received concerns in relation to safeguarding people, medicines management and meeting people's health and support needs. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has not changed and remains inadequate.
We found was evidence during this inspection that people were at risk of harm from this concern. Please see the safe, effective and well-led sections of this full report.

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

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to keeping people safe, medicines management and a lack of good leadership and governance systems at this inspection.

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

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. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Precious Homes Hertfordshire

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 Health and Social Care Act 2008.

Inspection team
The inspection team was made up of an inspector and a pharmacy inspector.

Service and service type
This service 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.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was not a registered manager in post, however there was a manager in post who had stated they were looking to go through the process of applying to be a registered manager.

Notice of inspection
This inspection was unannounced.

What we did before the 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 used the information the provider sent us in the provider information return (PIR). This information helps support our inspections. We used all of this information to plan our inspection

During the inspection
We communicated with five people who used the service about their experience of the care provided. Where people could not communicate verbally, we used different ways of communication using objects and their body language as well as observing interactions between people and staff. We spoke with three relatives.

We spoke with seven members of staff including the manager, operations' manager, support workers and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with one professional who had regular involvement with people using the service. We reviewed a range of records. This included four people's care records and three medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed. We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection people were at risk of harm. Systems were either not in place or not robust enough to demonstrate safety was effectively managed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not protected from abuse. Systems were either not in place or not robust enough to prevent people from potential abuse. 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.

Not enough improvement had been made at this inspection and the provider was in continued breach of regulation 12 and regulation 13.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- At the last inspection we found people's risk assessments were not clear or coordinated. Although in some cases there were improvements, we continued to find gaps with key aspects of their support. For example, we found one person was still at risk of harm because staff were not supporting them with safe manual handling. Although they had the equipment in place, staff were not trained to use this and nor was there a risk assessment to show the correct way to transfer the person. The person confirmed there have continued to be times where staff have not followed safe manual handling practices.
- Staff did not have the understanding and skills to support people safely and lawfully. We observed staff using restrictive practice when supporting someone, this included observing a staff member forcibly removing an item from a person's hands.
- At the last inspection we found that people's epilepsy was not managed safely. At this inspection we continued to find significant concerns about the safety measures in place. One person had a seizure and the staff member supporting them did not know where the emergency medicine was and did not feel confident in administering this medicine. Epilepsy equipment was not being checked correctly. When checking as part of the inspection we found these were either not in place or not working.
- The management team requested staff check the epilepsy equipment hourly. We found on two occasions this had not being completed. One staff member stated they had been documenting to say they had checked the epilepsy mat, however when asking how this was done, they continued to say they had not. This meant the records were falsified. Another staff member said they had not been checking the epilepsy monitor, upon checking the sensor the inspector found there was not a sensor present. During this visit the person had a seizure. This meant measures which should have reduced the risk of harm for people were not effective and people were not provided with safe care.
- The management team did not ensure accidents and incidents were looked at to see if there was any lessons learnt. During the inspection the management team started to complete lessons learnt following the findings from the inspection visit.

● People and relatives said they did not feel safe with the support they were receiving. A relative said, "I don't think [relative] feels safe."
● We found significant safety concerns. Following the first visit, we raised these concerns with the management team and were provided with assurances of actions to address them. However, we revisited the service to look to see if some of these assurances had been completed and found that these were still not actioned.

Using medicines safely
● At our last inspection, we found that the provider did not have safe systems in place to manage people's medicines in the service. On this inspection we found not enough improvement had been made. We identified several gaps in peoples' Medicines Administration Records (MAR) and therefore could not be assured that people always received their medicines as directed by the prescriber. For example, we saw one person with epilepsy was prescribed medicines to manage their seizures. On the day of inspection, this essential medicine was not administered to the person and the MAR had not been completed to document reasons for not administering the medicine.
● The provider failed to carry out regular stock counts of people's medicines. We found the medicines in original packs did not always correspond with the number of medicines administered to people. We therefore could not be assured that people were receiving their medicines as prescribed and there was a risk of peoples' health deteriorating.
● Where people were prescribed medicines to manage anxiety and behaviour on a 'when required' (PRN) basis, this was not always managed safely. For example, we saw one person was administered PRN medicines to manage 'aggressive behaviour' on three consecutive days. However, there were no records to demonstrate that staff had carried out any de-escalation techniques prior to administering PRN medicine. We therefore could not be assured that people's behaviour was not controlled by excessive or inappropriate use of medicines.
● Some people were prescribed medicines to be administered topically, including creams. However, records of application were not documented and therefore we could not be assured that peoples topical medicines were being applied as prescribed and effective in treating conditions.
● People were prescribed medicines in liquid form. Dates of opening these were not always recorded to ensure they were used within manufacturers recommended dates. We therefore could not be assured that when people were administered liquid medicines, that they gained the desired therapeutic effectiveness from them.
● People's care plans were not up to date and did not reflect up to date information about people's medicines as per their MARs. For example, one person's medicine to relieve constipation had been amended to a higher dose for over two months. However, the care plan did not reflect the updated dosing change. This could lead to confusion about what medicines people are currently prescribed.
● As a result of these concerns the provider employed a suitable trained person to administer medicines at the key times of the day to minimise the risk of errors.

Preventing and controlling infection
● At the last inspection we identified that people were not protected from the spread of infection. We found this continued to be a risk to people. The management team did not ensure effective infection prevention and control measures were in place to keep people safe. We observed staff not following safe practices when wearing personal protective equipment. We found staff not wearing masks correctly. This put people at increased risk of infection.

Systems were either not in place or not robust enough to demonstrate safety was effectively managed. This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● At the last inspection we found people were not always kept safe from abuse or treated with respect and dignity. At this inspection we found that some people were harmed and continued to be put at risk of harm. We observed one staff member forcibly remove an object from a person and not using safe moving and handling techniques when supporting the person. We observed staff stopping a person from leaving their flat, including through physical restriction of holding their wrists.

● People's care was at times degrading and neglectful. Staff had been made aware that a person's chair was wet, however they had not cleaned the sofa and continued to let the person sit on the sofa with a sheet over it. At the last inspection one person spoke about not having timely support which resulted in them laying wet in their bed. This person stated this still occurs on occasion.

● The management team did not have effective system in place when concerns were raised. Staff gave mixed views about how they felt that these were not always actioned appropriately which resulted in them feeling people were not provided with safe care. One staff member said, "Frustration of things going wrong, I have raised it. I feel they are not safe."

People were not protected from abuse. Systems were either not in place or not robust enough to prevent people from potential abuse. 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.

Staffing and recruitment

● At the last inspection people were keen to have a regular staff team that knew them well. This continued to be an issue. One person became extremely distressed due to the lack of induction for the staff member. Another person described how their support was taken away from them at times because other people were at more risk, however this had resulted in their mental health deteriorating and had impacted on them.

● The management team failed to manage the rota's effectively. Where people needed two staff to support them because of the complexity of their support needs, we observed they were not consistently getting the required level of support.

● Relatives spoke about their continuing to be a high number of staff turnover, which also included the management team. This meant that people did not always have consistent support. One relative said, "[Relative] seems to have some many different people. Agency staff. [Relative] needs to have a core team and they do not. They [provider] keep telling me they are getting people."

● At the last inspection we found that staff were not receiving regular breaks. At this inspection on the first visit, this was still the case. At the second visit the management team had ensured this was planned on the rota.

Inadequate

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 our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

At our last inspection people were at risk of harm. People were supported by staff who did not have the right skills or training to meet their needs. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was in continued breach of regulation 18.

Staff support: induction, training, skills and experience

- People were not always supported by staff who had the right skills. One person needed to be supported by staff trained in manual handling. We found that staff who were supporting this person had not completed this training and as a result where unable to use essential equipment to help with safe transfer. This put the person at significant risk of physical and psychological harm.
- We observed a staff member not having the skills to help support someone when they were having a seizure. The staff member did not have the confidence to know how to administer emergency medicine or in fact where the emergency medicine was located. The lack of staff knowledge and experience was raised in the last inspection which meant that people continued to be put at significant risk of harm.
- People and relatives did not always feel the staff team had the adequate skills to provide support for their loved one. One person said, "[Staff] didn't understand my support needs, I don't know them. I get anxious." One relative said, "Staff are not trained properly."
- The management team did not ensure staff were adequately inducted to the service. On the day of the inspection we found 5 out of 12 staff did not have appropriate inductions to understand the support needs of the people they were supporting. As a result, people were put at significant risk of harm. We asked for immediate assurances that new staff had the right skills and training as well as a full induction.

People were supported by staff who did not have the right skills or training to meet their needs. This placed people at risk of harm. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We found that there had been some improvements in some of the training sessions put on for staff since the last inspection; for example, learning disability and autism training.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- At the last inspection we found that people's care records were not always up to date or had the latest

guidance. We found improvements had been made with the content of some of the care plans, however they still missed some key information to support people's safety. For example, one person needed to use a manual hoist in the event their mobility deteriorated, this was not highlighted in the care plan.

● Further development was still needed to reflect people's long-term aspirations. Records showed that where the care plan had documented people's interests these were not seen through and people had little opportunity to go out of their home. One staff member said, "I don't think they have quality of life, they are all being shut into their own flats and left."

● People felt staff did not always know how to effectively support them. One staff member had started supporting one person without reading their care plan, this caused them great anxiety as it was important that the staff understood their support needs before supporting them. This made the person feel unsafe and put them at risk of harm.

Supporting people to eat and drink enough to maintain a balanced diet

● Relatives expressed concern about the lack of support people had to ensure they had food in their flat. One relative said, "I have gone to see [relative] and there is no food in the fridge."

● Staff were restricting people food intake without correct guidance to do so. Records detailed occasions when a person asked for food, the staff member stated they did not give this to them. The person's care plan did not give this level of detail nor was there any recommendation or best interest decision from health professionals.

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 MCA 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.

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● At the last inspection we found there to a lack of evidence of best interest decision and mental capacity assessments. At this inspection we requested evidence that these had been completed however, this was not done for example, we observed one person not able to leave their flat and there was no documentation to state where peoples food was restricted this was in their best interest and in consultation with health professionals.

● Where court of protection applications had been made, these had not been chased up since the last inspection.

The provider failed to ensure people had choice and control of their support and lacked evidence to show where they were depriving people this was in their best interest. This was a breach of regulation 11 (need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care;

- Where people required health involvement the staff supported them with the to contact the relevant professional.
- Since the last inspection professionals had been entering the home to support improvements for the service.

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 our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the culture of the service failed to support the provision of high-quality care and support. Quality monitoring systems were either not in place or robust enough to demonstrate the service was effectively managed. This placed people at risk of harm. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was in continued breach of regulation 17

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

- At the last inspection we identified there was a lack of consistent leadership. There had been a number of changes within management team. We found a number of failings identified in the last inspection had not been actioned. This meant there had not a consistent approach to change and improvement.
- Relatives said they did not feel the support their loved one received was well managed. A relative said, "I feel it has gone from bad to worse. ….[relative] is just existing at the moment they have not got a quality of life." Another relative said, "There has been a lot of changes of management and It is really hard. I have had problems with communication, where I have not had replies. Where I am saying we will have them home or help out I will get response. But If I am asking for answers, I will not get a response. I think they have been trying to sort certain things, I am not seeing significant changes."
- The management team did not consistently offer the opportunity for people and staff to share their views. The management team stated that since the last inspection there had not been regular team meetings, nor had people had the opportunity to formally speak about how they wanted their support.
- The provider had failed to identify that people were being supported by staff who had not got the appropriate skills.
- The provider and management team had failed to embed a robust quality assurance system. The management team stated there had not been regular audits within the service since the last inspection. This meant they were unable to have oversight of areas that needed improving.
- People did not feel listened to. One person became distressed when the manager had not responded to their request, we observed this request being ignored on three occasions. The manager was unaware of the impact of this and that this was the reason for the person becoming distressed.
- Our findings from the other key questions inspected showed that governance processes had not helped to keep people safe, protect their human rights and provide good quality care and support.

● Staff gave mixed views about the support they received from the manager. One staff member said, "I do not feel supported by the managers." Another staff member said, "I didn't have any major issues with the management recently but maybe this is also because I am quite capable when it comes to resolving any disputes." Another staff member said, "Communication seems to have got better over the last couple of weeks."

Quality monitoring systems were either not in place or robust enough to demonstrate the service was effectively managed. This placed people at risk of harm. This is a continuing breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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;
● The provider continued to fail to ensure people received support that was safe and met best practice guidance.
● The provider had made some steps to ensuring staff working in the service had the right values, however we continued to find that there were staff that spoke in a disrespectful way and supported people in a way that was not dignified.
● Following the previous inspection, the provider had shared the report findings from to people receiving the support and family members.

Working in partnership with others
● One professional we spoke with felt the provider had not ensured people were supported safely and that they had not seen improvements made over the recent months.