Care Quality Commission

Precious Homes Limited

Autus Court

Inspection report

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Date of inspection visit: 10 September 2015
Date of publication: 09/11/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on 10 September 2015 and was an unannounced comprehensive inspection. At our last inspection on 4 and 12 March 2015 the service was in breach of legal requirements relating to consent to care and treatment, care and welfare of people who use services, safeguarding people who use the service from abuse, management of medicines, and assessing and monitoring the quality of service provision. We told the provider to take action to ensure that these legal requirements were met. The provider produced an action plan telling us how they would achieve this.

The service provides accommodation with personal care for up to six people with learning difficulties and mental health needs. Four people were using the service at the time of this inspection.

The current acting manager had applied to become the registered manager and was awaiting a fit person interview. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, 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.

Summary of findings

At this inspection we found the provider had made improvements. We saw that medicines were managed safely and appropriately and people received their medicines as prescribed. Applications for Deprivation of Liberty Safeguards were made, care and treatment was planned and delivered to meet people's needs, planned programmes of activities were in place,

We observed good interactions between staff and people using the service. Staff knew the people they were supporting and understood their needs. However, people's care files contained out of date information and Health Action Plans (HAP) were not always updated following healthcare appointments and referrals to healthcare professionals were not always made in timely manner, although staff felt supported by senior management and knew people's needs, some staff had not yet received training in specialist areas such as autism awareness. Therefore they may not have up to date knowledge about people's conditions to better help them to support people. We saw that the service had a service improvement plan which identified most of the issues we found on the day of our inspection, however, some of these actions were still to be completed.

We found the service was in breach of Regulations relating to the safety of the building and risks associated with the environment.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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. Risk assessments for fire were out of date. Some unresolved maintenance issues posed a risk of harm to people using the service.

Staff showed awareness of safeguarding and how to report abuse but some staff had not been training on safeguarding people from abuse.

The service had a recruitment policy in place and staff were subject to the necessary checks.

Improvements in medications management have been evidenced since the last inspection.

Is the service effective?

Requires improvement

The service was mostly effective. Staff received supervision and said they felt supported by their managers. However, Staff did not always complete training in mandatory areas as specified by the provider.

Staff understood DoLS and the impact of this on people the people they cared for. However, further work was required to ensure that staff training in DoLS and MCA were up to date and mental capacity assessments were relevant to the support being provided. We also noted that people were being deprived of their liberty as they were unable to access the garden without staff assistance.

People's nutritional needs were met by the service, however, we noted that some out of date food in fridges and dried food not appropriately stored.

Is the service caring?

Good

The service was caring. We observed that people were treated with dignity and respect. Staff knocked on people's doors before entering.

We observed some good interactions between staff and people using the service.

People's likes and dislikes were recorded in their care records.

Relatives were not always involved in people's care and reviews of their support plan.

Is the service responsive?

Good

The service was responsive. People participated in activities of their choice.

There was a complaint system in place. We saw a pictorial complaints leaflet displayed for people using the service. However, relatives were not always happy with the way the service dealt with their concerns.

Summary of findings

The service supported some people to maintain contact with family and friends who were able to visit anytime.

Is the service well-led?

Requires improvement

The service was mostly well-led. Staff told us that they felt supported by the management approach.

People were protected from the risk of poor care and treatment because the provider had systems in place to monitor the quality of the service. However, health and safety audits were not effective in ensuring the building was safe

Autus Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 10 September 2015 and was unannounced.

The inspection team consisted of two inspectors and one specialist advisor in medicines.

Before the inspection we gathered and reviewed information from notifications and safeguarding alerts, previous inspections and interactions with the service.

The methods that were used during the inspection to gather evidence were talking to people using the service, their relatives, interviewing staff, observation, and reviews of records. We looked at policies and procedures, files for every person who uses the service and seven staff files.

People using the service had complex needs, therefore we were only able to obtain limited feedback from them. We spoke with one relative and one healthcare professional. We also spoke with four staff members, including the deputy manager, senior support worker and two support workers.

Requires improvement

Is the service safe?

Our findings

At our last inspection in March 2015 we found medicines were not managed safely. We found issues with poor stock control including inaccurate records of balances. We could not be confident that people received their medicines as prescribed.

During this inspection we found a number of improvements. We saw evidence of people's prescribed medicines on the Medicines Administration Records (MAR), medicines profiles in care plans and on copy prescriptions which all correlated. We found no omissions of allergies, receipts, administration and disposal. When medicines stocks were carried forward from one month to the next, staff recorded the quantities. This means that we were able to carry out audits of all medicines to check the accuracy of the records. All counts we did could be reconciled with the records. We noted one discrepancy where we were told that a tablet had been dropped, which had not been recorded on the MAR. When people were prescribed 'as required' medicines, for pain relief or for their mood there was a clear protocol in place so that staff knew how to identify the circumstances to give the medicine and in what dose and how often. We saw evidence of monthly stock audits and there were daily handover checks to ensure that all medicines were given and signed for appropriately. There was always a witness signature on the MAR to verify administration. Overall we were assured that medicines were being given safely.

Medicines were stored securely in the service and there was no excess stock or expired medicines observed. Daily temperature checks were carried of the medicines storage area and were within the appropriate range.

The home had medicine policies and procedures in place which had been updated in March 2015. We saw that two people were often absent from the service because of a social leave and that staff recorded the quantities of medicines they sent with the person in line with the procedures.

There was a policy for managing medicines errors and we saw a record of one in June 2015 when a person did not receive their night medicine. This was investigated and the appropriate action taken and recorded. Two people were prescribed medicines in case they suffered a seizure. We saw that both had seizure records but that only one had a care plan and risk assessments so that staff knew what to do if a seizure occurred.

A healthcare professional told us they felt their client was safe living at the service. However, a relative said that they are not told when incidents happened and they had to ask for updates on how their relative was doing.

During this inspection we found staff knew what to do if they suspected abuse and how to report a safeguarding issue. We looked at the service safeguarding procedure which was up to date and identified some mandatory training. We saw from the training matrix provided by the deputy manager that 14 out of 16 staff had completed mandatory safeguarding training.

The challenging behaviour policy which was due for review in June 2015 was looked at. It stated that all physical intervention should be recorded on the incident form and a 'physical intervention record' created. From the records we found that the provider had not followed their own policy. There were discrepancies with four of the incident records. Where some form of physical intervention was used, a physical intervention form was either not completed or the incident record did not reflect that a form had been filled out in accordance with the policy. The deputy manager informed us that this was something she was working on with staff as some staff needed more support to complete paperwork.

The staff rota showed that there were four staff members working during the day, with the addition of the deputy manager and the manager. During the night it showed there were two staff, one waking and one sleeping, and there was always one staff member recorded on the rota as being on call. During our inspection there were four staff members in the service at any one time with the addition of the deputy manager. When we spoke with staff they said they felt that there was adequate staffing to meet the needs of people using the service.

The deputy manager and director of operations told us that the use of agency staff had reduced, however, due to one staff member who had been promoted agency staff had been used to ensure that people's needs were met. The director of operations told us that a permanent staff member will be joining the service the following week. We asked the service to send copies of the rota for the last four

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weeks, this showed that agency staff were used. We noted from the rota that the same agency staff had been used over a period of four weeks. Staff told us that this sometimes had an effect on people using the service as the agency staff were often unfamiliar and did not know people and how to support them or manage their behaviour. A healthcare professional told us that the staffing levels were adequate.

The service had a recruitment policy and procedure. We reviewed staff personnel files for seven staff and found that these contained a number of gaps. We found three contained missing references and three had no confirmation of Disclosure and Barring Service (DBS) checks to ensure that staff were safe to work with people. The management team said they would follow this up, that a head office audit had been completed and all checks were in place but copies may be held at head office rather than in local staff files. Following our visit the deputy manager provided copies of the relevant references and DBS verification numbers.

Staff were able to explain areas of risk for the people they were supporting . We reviewed risk management plans for people using the service and found these were comprehensive and up to date. We found risks covered a wide range of risks specific to each individual with a clear management plan, such as risks posed when out in the community.

We observed that the last fire drill took place on 29 June 2015 with all the people using the service recorded as having taken part. Records of fire safety checks were being completed by staff weekly. The front door and garden door were coded entry which we were told was disabled when the fire alarm was activated to enable swift exit in the case of a fire emergency. Fire extinguishers were in place around the service in communal hallways in boxes attached to the wall and had been marked as being inspected in June 2015.

The fire policy stated, “Each Precious Homes Ltd site will have an up to date fire risk assessment.” Fire safety records reviewed showed that the fire risk assessment on file was out of date. However, following our visit to the service the provider sent a copy of an up to date fire risk assessment for May 2015. We observed that there were no extinguishers or a fire blanket present in the kitchen area. The deputy manager told us that fire equipment for the kitchen had been requested.

There were several maintenance issues that needed resolving. Some examples were holes in some walls, a cracked plug socket, and a light in a communal hallway not working causing the hallway to be dark and putting people at risk of tripping. There was a separate shower room located in the dining room area, we saw that the shower was blocked with mouldy furniture and a piece of wood with nails sticking out of it stored in this area. This put people at risk of unsafe premises because the provider had not taken immediate action to ensure people’s safety. The deputy manager told us that this should be locked as this was no longer used. She also explained that there had been a number of maintenance issues which she had reported but this had been slow to get resolved. We were shown a maintenance reporting tool covering two weeks of reporting and an email of the issues that were being chased up by the deputy manager. Overall we identified three trip hazards which put people at risk of harm from slips, trips and falls. These were located on steps in entrance hallway with a tear in the carpet, the dining room in the basement has a small bathroom with the flooring coming away from floor, and there was a hole in the carpet outside the lounge.

We concluded that this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was an up to date infection control policy in place. During our inspection we observed staff using gloves when entering a room to provide personal care. We saw colour coded mop buckets and posters explaining the areas to be cleaned. In the kitchen where staff prepared most of the food we saw that food was labelled in the freezer. The deputy manager told us that the staff did the cleaning during the day and that night staff were responsible for the deeper cleans. During our inspection we saw staff hoovering and doing laundry. There were checklists to tick to say if this had been completed and on display in the office we saw a cleaning rota. It had been noted in staff meeting minutes that staff needed to clean up as they went along during the day

However, we found some issues where infection control practices were not followed. The fridges contained some food items which were out of date and not labelled with opening dates. In the dry store cupboard there were opened and unlabelled dry foods. There was a separate handwashing sink and a poster reminding staff to label

Requires improvement

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food when opened. This had not been followed by staff. We saw that the window sill and windows in the kitchen area were dirty with layers of dust, and there were two unused microwave ovens stored in this area. One of the communal toilets did not have hand-soap and paper towels. The deputy manager said some cleaning tasks were not being completed so she planned to introduce unannounced spot checks including night visits to monitor this. We saw that some infection control processes were in place but these were not always followed to minimise the risk of cross infection or contamination.

There was a system in place for dealing with incidents and accidents. We reviewed accident and incidents records. We noted that since our last inspection in March 2015 there were 25 incidents recorded. The service provides support to individuals whose behaviour can challenge the service. The incident records were signed to say they were sent to the director of operations and relevant health care professionals and contained a management plan. One healthcare professional told us that incidents involving behaviours that challenged the service had reduced due to the way staff had worked with the person.

Requires improvement

Is the service effective?

Our findings

At our last inspection in March 2015 we found some staff had not completed Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA) training, despite this being mandatory requirement for the provider. DoLS authorisations were not in place for most people using the service, therefore people were being deprived of their liberty as they were not able to come and go as they pleased.

During this inspection we saw that applications for DoLS had been submitted to the relevant local authorities for all of the people using the service but no outcome had been arrived at for three of the four people using the service. A DoLS application is where a person can be lawfully deprived of their liberties where it is deemed to be in their best interests. We saw that the outstanding DoLS applications had been followed up by the manager via email. We noted that mental capacity assessments were completed in the files of two people using the service around their consent for people to look at their files, however, this did not cover whether people consented to receiving personal care or support. The deputy manager showed us evidence that she had listed areas where improvements were still required to ensure that all mental capacity assessments were in place. Staff demonstrated some awareness of DoLS and MCA, including the impact of these on the people they cared for.

We found that the service had a keypad lock on the front door and back door leading to the garden. We saw that people living at the service were not about to freely use the garden or go out the front door without staff entering a keypad code. The deputy manager told us that the lock on the front door was to keep people safe as they were unable to access the community without the support of staff. This was confirmed by records reviewed. The director of operations told us that the code to the garden door was initially put in place due to one person who no longer used the service and who was at risk of absconding and had left the service. People using the service were unable to use the keypad code as they had complex needs. People were currently living at the service were not able to freely access the enclosed garden space with staff assistance, therefore this was an unnecessary infringement on their liberty. We were told by the director of operations that this would be addressed immediately and the keypad lock removed.

One relative did not feel staff were appropriately trained. They commented, “I wonder if they [provider] are even training the staff they have got as they don’t seem experienced or trained in caring for young people with complex needs.”

Staff told us that they had completed an induction programme when they started to work for the service. They confirmed that they had received on the job training. The deputy manager provided us with a staff training matrix. This showed that staff had completed mandatory training in areas such as person centred thinking, record keeping, first aid and autism. However, we noted that there were low numbers of staff who completed training in areas such as autism, record keeping and fire safety. We saw from the training matrix that 11 out of 16 staff had completed positive behavioural support. Therefore staff may not be up to date with the latest guidance to ensure that people using the service were safe and cared for by skilled and qualified staff. The deputy manager told us that staff training had been noted as an area where further improvements were required and provided us with a list of training that that had taken place in August 2015 and September 2015. This included communication and autism, positive behaviour support, risk assessment, record keeping and person centred thinking. However, not all staff had been trained in how to manage challenging behaviour and use of physical intervention, yet physical intervention had been recorded as used in ten out of the 25 incidents looked at.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The service had a supervision and appraisal policies in place. These stated that supervision should take place at least once every eight weeks and appraisals on an annual basis. Staff confirmed that they had received regular supervision, but had yet to receive an appraisal which would be due in March next year. One staff member told us that supervision had helped them to see the progress they had made since the last supervision. Another staff member told us that the deputy manager was “hands on.” We reviewed supervision records for two staff and saw that supervision had recently taken place. We were unable to verify whether other staff had received supervision as

Requires improvement

Is the service effective?

records were not available on the day of our inspection. The deputy manager told us that she was not aware of where these were kept as she had been with the service for a few weeks and the manager was on leave.

People were given a choice of food and drinks and we saw that each person had a menu, which was also pictorial. The deputy manager told us that shopping for the service took place twice weekly and two people living at the home assisted with this. Staff had good knowledge of people's appetite and meal regime, their favourite meals and their likes and dislikes. We observed people accessing the kitchen with staff to prepare breakfast and at lunchtime. One person told us that what they liked for breakfast and this was confirmed by staff who supported them.

People had access to healthcare services. We saw evidence of appointments with people's GP, psychiatrist and dentist. The visits had been documented in the person's Health Action Plan (HAP) and in the staff communication book. We spoke with a healthcare professional who told us that they had been kept up to date with appointments following an injury. Although health care appointments had been documented, the outcomes of these were not always updated in people's health action plans. We also noted that there had been delays in making referrals to healthcare professionals. Although the healthcare professional felt staff worked well with the person, the referral to a specialist regarding their health took longer than expected. The manager told us that although this work had started, further improvements were required to reorganise people's care files. This was noted in the service improvement plan which showed that this work was in progress.

Good

Is the service caring?

Our findings

A healthcare professional told us that they felt staff were caring and kind, understood people's needs, and worked well with the person they had placed at the service.

We observed several interactions that showed staff were caring and knew people's preferences and behaviours well. Staff interacted with people according to their individual communication needs. Staff were able to communicate with each person using sign language that was unique to the person. For example, through the use of drawings to communicate with one person. There were pictorial explanations on display in the service catering to people's different needs and understanding.

Staff treated people with dignity and respect and spoke in a caring and respectful manner towards them. Staff were able to tell us about how they respected people's privacy and dignity. We observed staff knocking on people's doors, announcing themselves and waiting before entering. We saw that people receiving personal care had their doors closed and staff talked to each other to make them aware that this would be taking place. We noted that staff encouraged one person to get dressed who was undressed in communal areas, thereby maintaining their dignity.

We saw that each person had a keyworker who held monthly meetings with them. This included looking at areas where people thought the service could have done better to improve the work they do with the person. The meetings also considered people's likes and dislikes and the type of activities they enjoyed participating in. Staff knew the people they were responsible for keyworking and gave us examples of how they provided support. Such as how people preferred to have their personal care and things they used to do before coming to the service.

We noted that care files contained several documents, including an updated support plan. These contained a background of people's histories, this helped staff to better understand people's needs. However, there were a number of out of date documents which made it difficult to know which document contained the most up to date information. Additionally, some the information had been repeated.

Good

Is the service responsive?

Our findings

A relative told when they asked for their relative to be dressed more smartly the service responded to this and made some changes.

People participated in various activities in the community. We saw that each person had an activities plan displayed in the communal hallway with pictures indicating the places where people liked to visit. On the day of our inspection we saw people going out into the community to attend their chosen activity, although there was some flexibility if people wanted to change their activity choice.

People's independence was encouraged by most staff, this included going shopping to help with buying food for the service. Other areas of independence included cake baking and helping with laundry. We observed one person assisting staff in the laundry room on the day of our inspection. Staff knew people's individual needs and were able to give us examples of how they met these. For example, assisting someone who liked changing their bed linen each morning, this was accommodated by staff who understood what this meant for the person. One person who enjoyed going on long walks and bus rides, did this on the day of our inspection. Another person liked doing housework so did this each day. This was confirmed by a healthcare professional. They felt the person went out enough.

People were involved in the running of the service. We saw evidence that monthly 'keyworking sessions' involving staff and people who used the service. This included discussions about what people liked to do at the service, what could be done better to improve the way the keyworker works with people, what activities people would like to do and whether people liked the food

People were involved in personalising their rooms. We were invited into two people's rooms and saw that these had pictures of people's choices and other personal items. One person who used the service told us that they enjoyed going to the cinema and were getting ready to be taken out by staff in the afternoon. We saw this documented in the person's support plan.

The service had a complaints policy in place. We saw evidence that people were assisted by staff to complete a feedback form 'people we support.' This includes communication and whether they knew how to make a complaint. We saw that there was a pictorial complaints procedure displayed on the wall in the communal hallway, to help people access the complaints process

Requires improvement

Is the service well-led?

Our findings

At our last inspection in March 2015 we found that although systems were in place to monitor the quality of the service these were not always effective in ensuring that support plans and risk assessments were up to date and medicines were safely managed.

During this inspection we found the acting manager had applied to become the registered manager for the service and was waiting for to be interviewed by the CQC. The service had recently appointed a deputy manager who had worked with the provider for some time. Staff said they felt supported by senior staff at the service. A healthcare professional told us that they felt the service was a good one and they were happy to approach the manager or staff if they had any concerns.

We found that although there had been improvements to the way medicines were managed and records for people using the service since our last inspection in March 2015, further improvements were required to ensure that people's care files contained the most up to date information. We saw from the provider's 'service improvement plan' dated 10 August 2015, that work to review individual files and identify out of date paperwork was due to be completed on the 15 September 2015. The deputy manager told us that she would be taking responsibility for this area of work and was aware that further improvements were needed. Staff told us that they have felt supported by the deputy manager who had a hands-on approach. However, systems to monitor the health and safety of the environment had not been effective at ensuring that people were safe at all times, staff training in some mandatory areas had not been completed and records relating to supervision were not available for all staff.

Staff safety was discussed with staff and the deputy manager. Staff said they felt safe and when asked what they would do in an incident if they were upstairs alone they said they would shout out for help. The lone working policy says that a lone working risk assessment is needed at every site, however, we found that there was no service lone working risk assessment in place and the service could not evidence that it had adequate risk assessments, procedures or safety equipment such as a personal alarms in place for staff if they were put at risk and needed immediate assistance.

The provider had a strategic plan for 2015 to 2016 which included the provider's values such as having people at the centre of what they do, giving people choice, independence and control, treating people with dignity and respect, and being outcome focussed and financially viable.

An external audit completed in July 2015 reviewed a number of areas, including medicines, support plans, risk assessments and Health Action Plans (HAP). This highlighted the need to ensure that a HAP should be updated. The manager completed a monthly quality and performance audit which included an overview of what had been learnt and any concerns, as well as what the service was doing well. We saw that this included details of the redesign of the garden and sensory fixtures. The director of operations and the deputy told us of the provider's plans to relocate the sensory room, which we saw was unused, to a building in the garden and to develop a semi independent living area at the top of the premises.

People were asked their views about the service. We saw that the provider had asked people living at the service their views using a questionnaire. Staff had supported people where necessary to complete these. This covered areas such as food choices, privacy, staff, social and bullying. Most people had indicated that they were very happy living at the home.

Policies and procedures were in place and staff were required to sign that they had read these and specific guidelines to relating to people using the service. The deputy manager told us that they had reviewed all their policies and procedures. We saw this on the day of our inspection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users. In particular, this included failure to ensure that the premises is safe to use and is used in a safe way. Regulation 12 (1)(2)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff did not always receive appropriate training or professional development, as was necessary to enable them to carry out the duties they are employed to perform. Regulation 18(2)(a)