Precious Homes Limited

Precious Homes Wembley

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

About the service:

• Precious Homes Ltd is a supported living scheme providing personal care support for up to 20 people with learning disabilities and complex needs.
• The scheme comprises studio flats in a large detached house with additional communal living areas, and is in Wembley.
• The scheme covered a range of areas including prompting with medicines, personal care, weekly shopping, housework and laundry.

People's experience of using this service:

• People received personalised care and support specific to their needs and preferences. The scheme was responsive to people's individual needs and delivered care that supported people's choices, and thus enabling them to achieve their potential and meet their goals. We saw examples where the scheme had transformed people's lives through evidence based person centred approaches.
• People felt safe in the care they received from care workers. There were safeguarding systems and processes to support care workers to understand their role and responsibilities to protect people from avoidable harm. Risk assessments were comprehensive and up to date, with detailed guidance for care workers on how to reduce identified risks.
• People's needs were assessed, and care delivered in line with standards and guidance. Care workers were trained and skilled so that they could support people in line with the required standards. They had also received training to ensure their knowledge and practice reflected the requirements set out in the Mental Capacity Act 2005 (MCA). They supported people to eat and drink enough to maintain a balanced diet. They supported people to live healthier lives and to access healthcare services and support.
• People's diversity and human rights were highlighted in their care plans. Referrals included a section relating to people's diverse needs such as their religion, culture and ethnicity. People were treated with dignity and respect. They were supported to maintain their independence.
• The scheme was well-led. Throughout this inspection, we observed practices and behaviours that were consistent with the values of person centred approaches. The registered manager and staff were clear about their roles. They understood quality performance, risks and regulatory requirements. There was range of quality assurance systems and processes in place to drive improvement. Areas of improvement were identified and we saw examples of lessons learned to prevent reoccurrences.

Rating at last inspection:

At our last inspection, the service was rated 'Good'. Our last report was published on 21 June 2016.

Why we inspected:
• This was a planned inspection based on the rating at the last inspection. The service remains Good.

Follow up:
• Going forward we will continue to monitor this service and plan to inspect in line with our inspection schedule for those services rated Good.

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 safe.	**Good**
Is the service effective? The service was effective.	**Good**
Is the service caring? The service was caring.	**Good**
Is the service responsive? The service was responsive.	**Good**
Is the service well-led? The service was well-led.	**Good**

Precious Homes Wembley

Detailed findings

Background to this 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:

Our inspection was completed by one adult social care inspector and a bank inspector.

Service and service type:

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:

We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

What we did:

• Our inspection was informed by evidence we already held about the scheme.
• We asked the service to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.
• We spoke with 8 out of 20 people who used the scheme and two relatives.
• We spoke with the provider's service manager, registered manager, team leaders and care workers.
• We reviewed eight people's care records, seven personnel files of care workers, audits and other records about the management of the service.
• We requested additional evidence to be sent to us after our inspection. This was received and the

information was used as part of our inspection.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At this inspection we found that people continued to be safe and protected from avoidable harm. People told us that they felt safe. This view was shared by their relatives.

Good: People were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse:
• People felt safe in the care they received from care workers. One person told us, "I have never been concerned about my safety." We received similar feedback from other people using the scheme.
• There were safeguarding systems and processes to support care workers to understand their role and responsibilities to protect people from avoidable harm. This was included in relevant policies such as those related to safeguarding, whistleblowing and harassment.
• Staff had received safeguarding training. They were aware they could raise concerns through relevant policies and were confident any concerns raised would be dealt with effectively to make sure people were protected.
• Examples were seen of appropriate actions being taken when concerns were identified. This included reporting concerns to their line manager, police and the Care Quality Commission (CQC).

Assessing risk, safety monitoring and management:

• There were effective systems and processes in place to minimise risks to people. Support plans included risk assessments covering a range of areas, including the environment, nutrition, activities, and specific behaviours.
• Each person's assessments were personalised to them. For example, staff were conscious of the triggers to specific behaviours that may challenge the service and were aware of the best and least restrictive way to make sure people were safe.
• The risk assessments were reviewed on a regular basis, which ensured people's safety and wellbeing were monitored and managed appropriately.

Staffing and recruitment:

• Care workers had been recruited safely. They underwent appropriate recruitment checks before they started to work at the scheme. Pre-employment checks had been carried out. Checks included, at least two references, proof of identity and Disclosure and Barring checks (DBS).
• The scheme was proactive in ensuring there were enough competent care workers employed. Two care workers had been recently recruited, but several had worked for the scheme for two years or more.
• There were sufficient numbers of care workers on shift at the time of inspection to provide people with the support they required. We observed people were receiving the support they were assessed as needing.
• The rota was planned around appointments and activities of people. Therefore, there were more care workers on some days than others.

• The scheme had an on-call system to make sure care workers were supported outside the office hours. There was a pool of bank care workers who could be used for additional support when needed.

Using medicines safely:

• There were systems in place to ensure proper and safe use of medicines.
• Care workers were suitably trained to administer medicines, and records were accurately kept. They were required to complete training and a competency assessment before administering medicines on their own.
• • Care workers were aware of the effects of medicines overdose. For example, one person had an inhaler they could use at any time. When this person's regular medicines were being administered, care workers enquired about the PRN (when required) use so they could keep an eye on how much the person was needing during the day or night time.
• People were encouraged to have flu jabs from their GP practice or local pharmacy.

Preventing and controlling infection:

• People were protected from the risks associated with poor infection control.
• Care workers were trained in infection prevention and control and had access to personal protective equipment, including disposable gloves and aprons.
• Sharps bins were appropriately labelled and collected by the pharmacy.

Learning lessons when things go wrong:

• There was a system for managing accidents and incidents to reduce the risk of them reoccurring.
• There was evidence of the scheme working with the police, and other agencies, where necessary, when investigations took place.
• The scheme had clear records to show how they had managed incidents, including following up on the outcomes of investigations.
• Care workers had a debrief following incidents to identify learning points. People were also asked of their views on how care workers had managed incidents. This helped care workers and management to understand the incidents from people's point of view.

Good

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

People's outcomes were consistently good, and people's feedback confirmed this.

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

• People's needs were assessed, and care delivered in line with standards and guidance. We observed practice that reflected national best practice and guidance such as, Positive Behaviour Support (PBS) approach, REACH and MAPA (Management of Actual or Potential Aggression).
• PBS approach identifies early warning signs that challenging behaviour may occur and suggests de-escalation and distraction techniques prior to crisis management. This was fully understood by care workers.
• 'Reach' are a set of standards that were created to ensure that supported living focuses on ensuring each person can live the life they choose with the same choices, rights and responsibilities as other citizens. For example, we saw evidence the scheme supported people to choose where they wanted to live, how they wanted to be supported, and who they chose to live with.
• The scheme obtained as much information about a person prior to their moving in. They sought information from a range of professionals, the person and the person's family. The referrals set out essential background details about people, including what support was being requested.
• People went through a transition process before they finally moved in. For example, one person was expected to move into a vacant flat at the scheme and was visiting the scheme regularly for a few hours a day to get accustomed to the idea of moving from the family home and meeting people who were already living there.
• Assessments covered areas such as nutrition, moving and handling, communication, health and safety, and relevant medical conditions. Care plans included guidance about meeting these needs.

Staff support: induction, training, skills and experience:

• Care workers were trained, skilled and experienced in their role. They spoke highly of the quality of training they received and the responsiveness of the registered manager in arranging training in topics they felt would be helpful in working with people.
• Care workers had completed essential training, which covered a range of areas, including, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), safeguarding, health and safety, equality and diversity and infection control.
• Care workers had also completed training that was tailored to the specific needs of people, including, autism awareness, challenging behaviour, diabetes and MAPA.
• All care workers received regular supervision and appraisals. Regular spot checks of competence and practice were also undertaken.
• Care workers spoke positively about their line management. One care worker told us, "We are free to

contact our managers should we have any queries and we are always supported."

Ensuring consent to care and treatment in line with law and guidance:

• People's rights were protected because the scheme ensured that the requirements of the Mental Capacity Act 2005 (MCA) were met.
• Initial capacity assessments were undertaken by senior managers. The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
• None of the people at the scheme lacked capacity. Nevertheless, care workers respected that sometimes people made unwise decisions and therefore supported them where necessary to keep them from harm.
• Care workers received training to ensure their knowledge and practice reflected the requirements set out in the MCA 2005.
• People told us they were always asked for their consent before care workers supported them and we observed this. This was confirmed by care workers we spoke with and care documentation.
• Where possible, people, or their next of kin, had signed the care records to show that they had consented to their planned care, and terms and conditions of using the scheme. People who took part in their care reviews had agreed to this.

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

• People were supported to eat and drink to maintain a balanced diet.
• Care workers supported people with shopping and meal preparation, encouraging them to buy food for a balanced diet.
• We saw that care workers gave support on diet and weight control to a person with diabetes and helped educate the person about how to identify healthy food by talking with them and showing them supporting videos.
• People were protected from malnutrition and dehydration. We saw from documentation that one person was reluctant to spend money on food and drink without encouragement, so care workers supported them to shop weekly and helped them prepare meals.

Staff working with other agencies to provide consistent, effective, timely care:

• There were several examples where the scheme had worked with other agencies to provide consistent and timely care.
• The scheme had made links with local leisure facilities and employers who offered work placements, and paid employment to help people find ways to spend their time.
• In some examples, the scheme offered outreach services to people who were moving on, until they settled in their new placements. At the time of this inspection, the scheme was supporting one person on an outreach basis. This involved coordinating roles with other providers.

Supporting people to live healthier lives, access healthcare services and support:

• Care workers supported several people to take exercises. Some people went swimming or running with a local group. One person had expressed interest in rock climbing and care workers had helped them find somewhere to do this.
• Care workers supported people in educating them about the risks of smoking.

• People were supported to access healthcare professionals. Care workers supported people as needed to attend appointments with doctors, dentists, hospitals, psychologists and psychiatrists. Care workers attended appointments so they could help people to follow up the recommendations from healthcare professionals. One person told us, "Staff will help me to go and see my doctor if I am ill."

Good

Is the service caring?

Our findings

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

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity:

• Care workers had a good understanding of protecting and respecting people's human rights. They had received training around equality and diversity.
• People's diversity and human rights were highlighted in their care plans. Referrals included a section relating to people's diverse needs such as their religion, culture and ethnicity. This ensured care workers were aware if they needed to make reasonable adjustments to meet people's needs.
• For example, some people attended church services and the scheme had considered this when deciding on which care workers will be working with them. We also saw that people were supported to be open about their sexual orientation or gender identity. Through individualised support one person was referred to a gender clinic where they received advice, support and mentorship for the first time in their life. This person was being supported to access socially appropriate activities and to integrate within the wider LGBT (Lesbian, Gay, Bi-sexual and Transgender) community.
• People had been asked if they had any preferences for male or female care workers. Where a preference had been identified this was respected.
• The scheme marked religious festivals, holidays and observances. This was commended by a relative who had attended one of these events. The relative commented, 'It is so great that you have these events. Your Black History event is interesting. I hope that you will be able to do more of them'.

Respecting and promoting people's privacy, dignity and independence:

• Most people could communicate with us in ways we could understand. They told us care workers were helpful and friendly. One person told us, "My keyworker knows me very well. She has always been kind to me."
• We observed caring behaviour from care workers. One person had suffered a bereavement and returned to the family home. The service was keeping in touch with the family.
• One person was fond of animals and kept a rabbit. Care workers brought in food for the rabbit and asked the person about its welfare.
• One person said care workers had been sympathetic when their relative went into hospital, which meant the relative could not go with the person on a planned trip.
• Care workers introduced the CQC inspectors to people and people understood who we were and why we were there.
• We saw care workers asking people of their preferences. We observed one person was planning to make a

list with their care worker of what they would take with them on holiday.
• The scheme recognised people's rights to privacy and confidentiality. Care records were stored securely in locked cabinets in the office and, electronically.
• Confidentiality policies had been updated to comply with the new General Data Protection Regulation (GDPR) law.

Supporting people to express their views and be involved in making decisions about their care:

• Some people had difficulty reading and care workers made use of pictures where this was the case.
• Care workers ensured that people were involved in decisions about their support and made plans with people. For example, they negotiated with people who had difficulty managing their money that a daily allowance would enable them to buy things they needed throughout the week.

Good

Is the service responsive?

Our findings

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

At our last inspection people told us they received person centred care which, ensured their individual needs and preferences were met. At this inspection we saw that the scheme had built on this, and people now described the scheme in even more complimentary terms. We found the service was responsive to people's individual needs and delivered care that supported people's choices, and thus enabling them to achieve their potential and meet their goals.

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:

• People told us that they received personalised care that met their needs. One person told us, "This is a fantastic scheme." Another person said, "The scheme is excellent and terrific." This was a common theme in other feedback received.
• Relatives thought the service was exceptional in the way it responded to people's needs. A relative commented, "The service has been excellent in meeting my relative's needs. My relative is now able to do things we never dreamt they could do before."
• We observed people received personalised care and support. Their care needs had been fully assessed and documented prior to receiving care.
• We looked at the care files of eight people. Each considered the person as an individual, with their own unique qualities, abilities, preferences and challenges. Care plans were detailed and reflected people's likes and dislikes.
• The scheme followed a PBS approach. We saw evidence this had ensured the service could meet the needs of people who displayed or were at risk of displaying behaviours which challenged the service without recourse to physical interventions.
• In one example, a person using the scheme had moved from a hospital setting. Prior to moving in, they were at risk of harming themselves or others. As a result, when they moved in, they were provided with 1:1 care for a significant number of hours per week. This also included a 1:1 waking night support. Within 12 months of moving in, their individual care hours reduced dramatically as they were now fully independent and no longer requiring 1:1 support.
• Another person had moved to the scheme due to breakdown of their previous placement. When they initially moved in, they also required a significant amount of 1:1 support hours due to their complex needs. The scheme worked with specialists to identify areas of need, which led to person centred support. Gradually the hours of support were reduced. The person became more independent and secured employment at a local shop. Eventually, the person was supported to move back home, with outreach support, which was only needed for a short period.
• In a third example, one person moved to the scheme whilst struggling to manage their diabetes. From speaking with care workers and records reviewed, their blood sugar levels were uncontrollable. Part of the reasons, was lack of knowledge relating to the management of the condition. The scheme with specialist

support worked to improve the person's understanding of managing their condition which in turn resulted in the person's health being well managed. This person shared their journey in successfully managing their condition at an event held to mark World Diabetes Day to raise awareness to other people with learning disabilities.

Communication:

• All providers of NHS care or other publicly-funded adult social care must meet the Accessible Information Standard (AIS). This applies to people who use a service and have information or communication needs because of a disability, impairment or sensory loss. There are five steps to AIS: identify; record; flag; share; and meet. The service had taken steps to meet the AIS requirements.
• Information was presented in different ways for people to enable them to communicate to the best of their abilities. The care notes documented communication impairments, and steps were implemented to ensure information was provided to people in a way they could understand. For example, we saw several examples of communication tools, each tailored to the specific needs of the person. Documents in the lounge were in easy read format and pictures and large fonts were used to record care plan reviews.
• The scheme also sought help from a specialist support to enhanced people's communication. In one example, staff had worked with one person to create a person-centred recovery passport related to their medical condition, visual time table, communication book/boards and PECs (Picture Exchange Communication System).

End of life care:

• All people were asked about end of life care and this was recorded in their care plans. Most people were relatively young adults. Some did not want to have this discussed and some had their wishes, which were recorded.
• In one example, the scheme supported a person during a difficult time whilst a loved one was terminally ill and during their bereavement process.
• The whole team at the scheme received loss and bereavement training in order to understand this person's needs and how they could support them during this difficult period in their life.

Improving care quality in response to complaints or concerns:

• The service had a complaints procedure which people and their relatives were aware of. The procedure explained the process for reporting a complaint.
• People felt they would be listened to if they needed to complain or raise concerns. They told us they could discuss any concerns they had with the registered manager and were confident any issues raised would be dealt with.
• There was a total of five complaints, which had been investigated and concluded satisfactorily.

Good

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.

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person centred care.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility:

• People received high quality care and support. This is because care was based in person centred approaches such as PBS and 'Reach'. Throughout this inspection, we observed practices and behaviours that were consistent with the values of these approaches.
• People were provided with the necessary support to develop skills for increasing independence to meet their life goals. There were several examples of people having regained independent living skills since moving to the scheme.
• The leadership complied with the duty of candour. This is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. We had been notified of significant events.
Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:
• There were clear management structures in place. The registered manager was supported by two team leaders and a service manager.

• Care workers were clear about their own roles and those of other staff, including staff from the head office. They were aware of their responsibilities and the reporting structures in place within hours and out of hours.
• We found the registered manager to be passionate and dedicated to providing quality care. She was knowledgeable about issues and priorities relating to the quality and future of the scheme.
• The management understood quality performance. They shared with us a service improvement plan. This showed how they were performing against key performance indicators such as those related to quality of care records, training, recruitment, and implementation of PBS.

• There was an open culture within the scheme. Care workers told us that they could raise any issues at team meetings and felt confident and supported in doing so. We evidenced this from minutes of team meetings. The scheme also sought feedback from people, people's relatives and staff, which it acted on.

Continuous learning and improving care:

• There was range of quality assurance systems and processes in place to drive improvement. This included regular surveys, audits and monitoring of accidents and incidents.

• Areas of improvement were identified and we saw examples of lessons learned to prevent reoccurrences. For example, it had been noted that people who lived at a sister scheme, which had since been closed, were at risk of financial abuse. We saw that scheme had taken lessons from the findings of the investigations at the sister service. People received appropriate support with the management of their finances. Their money was subject to a regular audit to reduce the risk of financial abuse. Each entry on the individual account record was countersigned to provide a witness to each transaction. A financial audit trail was kept for each person using the service and this was made available to us.

Working in partnership with others:

• The scheme worked together and with other health and social care professionals to understand and meet people's needs and to assess and plan ongoing care and support. This included when people where moving between services, including when they were referred, or moving on to live where they had chosen.
• We saw that Information was shared between services, with people's consent. Meetings took place with other health care professionals on a regular basis when care plans were routinely reviewed and updated.