Precious Homes Limited

Prince Regent House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place over two days on the 7 and 12 January 2016 and was unannounced. This was the first inspection of this service since it was registered with the Care Quality Commission.

The service provided support with personal care and accommodation to adults with learning disabilities who were on the autistic spectrum. They were registered to provide support for a maximum of ten people. Six people were using the service at the time of our inspection.

The service had a registered manager in place. 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.

The service had appropriate safeguarding procedures in place and staff were knowledgeable about their responsibilities with regard to safeguarding adults. Risk assessments were in place which included supporting people who exhibited behaviours that challenged the service in a safe manner. There were enough staff working at the service to promote people's safety and pre-employment checks were carried out on prospective staff. Medicines were stored, recorded and administered in a safe manner.

Staff were supported in their role through regular training and supervision. However, most staff had not undertaken training about autism. The service was working within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. People were able to make choices about their daily lives. This included choices over what they ate and drank. People had access to healthcare professionals as required.

People told us they were treated in a respectful manner by staff and we saw staff interacted with people in a caring way. The service sought to promote people's privacy, dignity and independence.

People and relatives told us the service was meeting their needs. Care plans were in place which included personalised information about how to support individuals. People had access to a range of activities within the community. The service had a complaints procedure in place which was accessible to people.

People that used the service, their relatives and staff told us there was an open management culture at the service and that the management team were helpful and supportive. The service had various quality assurance and monitoring systems in place. Some of these included seeking the views of people that used the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff undertook training about safeguarding adults and safeguarding allegations had been dealt with appropriately in line with the provider's procedures.

Risk assessments were in place which included information about how to mitigate risks people faced, including in relation to behaviours that challenged the service.

There were enough staff working at the service to meet people's needs in a safe manner. Checks were carried out on staff before they began working at the service including employment references and criminal records checks.

Medicines were stored, recorded and administered in a safe manner.

Is the service effective?

Requires Improvement

The service was not always effective. Although staff had access to regular training and supervision, most staff had not undertaken training about autism.

The service was working in line with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. People were able to make choices about their daily lives including what they ate and drank. People told us they had sufficient amounts of food and drink.

People had access to healthcare professionals as required.

Is the service caring?

Good

The service was caring. People told us that they were well treated by staff. We observed staff interacted in a respectful manner with people and people were at ease with staff.

Staff were able to explain how they promoted people's dignity, privacy and independence.

Is the service responsive?

Good

The service was responsive. Assessments were carried out of people's needs before they moved in to the service to determine if the service was able to meet their needs. Care plans were in place which were personalised and based around the needs of individuals. People had access to a range of activities within the home and the community.

The service had a complaints procedure in place. People and relatives were knowledgeable about how they could make a complaint if required.

Is the service well-led?

Good

The service was well-led. There was a registered manager in place. People that used the service and staff told us they found the management team to be supportive.

The service had various quality assurance and monitoring systems in place. Some of these included seeking the views of people that used the service.

Prince Regent House

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 over two days on the 7 and 12 January 2016 and was unannounced. The inspection team consisted of one inspector and a specialist advisor who was a specialist in the Mental Capacity Act 2005 and adults with learning disabilities.

Before the inspection we reviewed information we already held about the service. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at safeguarding and other notification we had received and contacted the local authority with responsibility for commissioning care from the service to gain their views.

During the inspection we spoke with two people that used the service and spoke with a relative by telephone after we had visited. We spoke with seven staff including the registered manager, two deputy managers, a senior support worker and three support workers. We observed how staff interacted with people that used the service. We examined three sets of care records which included support plans and risk assessments, six sets of staff recruitment, training and supervision records, medicine records, financial records relating to people that used the service, various quality assurance audits and surveys and policies and procedures.

Good

Is the service safe?

Our findings

People and their relatives told us the service provided safe support. A relative said, "Yes I do feel he is safe, and they continually re-assess the situation (to ensure continuing safety)."

The provider had a safeguarding adults procedure in place. This made clear their responsibility for reporting any allegations of abuse to the relevant local authority and the Care Quality Commission. The service had a whistleblowing procedure and we saw details about whistleblowing displayed on the office wall. This included advising staff that they had the right to speak out if they were concerned about areas of poor practice within the service. We found that safeguarding allegations had been dealt with appropriately in line with the provider's procedure.

Staff told us and records confirmed that they had undertaken training about safeguarding adults. Staff were knowledgeable about the different types of abuse and were aware of their responsibility for reporting any safeguarding allegations to senior staff. One member of staff said, "The first thing I would do is report it to my manager and I can whistle blow if things are not done about it."

Where the service held money on behalf of people safeguards were in place to reduce the risk of financial abuse. Monies were stored in locked safes. Receipts were kept of monies spent and staff signed whenever they spent money on behalf of people. Records were kept of monies held. We checked the amounts of money held on behalf of people and found the amounts tallied with the records of how much each person had.

Staff were able to explain how they supported people who exhibited behaviours that challenged the service. They said 'as required' (PRN) medicines were available and at times they had to use physical intervention to restrain people. However, they told us these were used as a last resort only when there was a clear risk to the person or others. They told us before it became necessary to use restraint they tried to de-escalate the situation through offering people re-assurance and helping them to become calm. One staff member said, "Restraining someone is the last thing we will do and only if they are attacking someone." Risk assessments indicated that physical intervention was only to be used as a last resort. Staff had undertaken training about the safe use of physical intervention and de-escalation techniques. Records were maintained of any incidents involving the use of restraint which detailed the reason why and what alternatives had been attempted before by staff before physical intervention was used.

As well as behaviours that challenged the service other risk assessments covered vertigo, using public transport and food and fluid intake. We found that one person had recently exhibited behaviours that put themselves and others at risk. There was no updated care plan for this but the registered manager was able to demonstrate the service was seeking the support of relevant care professionals to provide support with this behaviour. They said they would work with the professionals to develop and implement a revised risk assessment.

There were enough staff to meet people's needs. Staff on duty were allocated to work with an individual

person and people's staff support levels were based on their assessed and individual needs. For example, one person required 1:1 staff support, while another person required 2:1 staff support which was increased to 3:1 staff support when they were in the community. We observed that staffing levels during our inspection were in line with people's assessed needs. Staff told us they had enough time to meet people's needs and support people in a safe manner. One staff member expressed concerns that there were plans to reduce the number of staff working during the night by one. They told us that this meant they would not have enough staff to provide support to one person who was assessed as needing four staff to support them with physical intervention when they exhibited behaviours that challenged the service. We discussed this with the registered manager who told us that since the relevant person had moved into the service there had not been any incidents of challenging behaviour during the night time and therefore felt it did not constitute a risk by reducing night time staffing levels. Care staff confirmed that to date all incidents of challenging behaviour involving the person had occurred during the day time. One staff member said, "Staffing levels are all right and we work as a team."

The service had robust staff recruitment procedures in place. Staff told us and records confirmed that various checks were carried out on them before they commenced working at the service. These checks included criminal records checks, employment references and proof of identification. This meant the service had taken steps to help ensure that suitable staff worked at the service.

Before staff were able to administer medicines they had to undertake training about this. The training included an assessment of their competence to administer medicines. Medicines were stored securely in locked and designated cabinets inside a locked medicines room. Controlled drugs were stored in a separate controlled drugs cabinet which had an extra degree of security. Two staff signed each time a controlled drug was administered. We checked the amounts of controlled drugs held in stock and found they matched the amounts recorded as being in stock.

We found that the service checked the stock of all medications held on a daily basis. Records were kept of medicines entering the service and of those that were disposed of. Medicine administration record (MAR) charts were in place which included the name, strength, form and dose of each medicine to be administered. We checked MAR charts for a five week period leading up to the date of our inspection. The MAR chats were found to be accurate and up to date except for one discrepancy. This was where an X had been entered on a person's MAR chart instead of a staff signature or a designated letter set out on the MAR chart key code. This meant it was not possible to tell if the person had received that particular dose of medicine. We discussed this with the deputy manager who was unable to account for this but told us they would carry out an investigation in to this incident.

Requires Improvement

Is the service effective?

Our findings

People told us they were happy at the service. One person said, "It's nice here." People said they were able to make choices about their daily lives. One person told us, "I buy the shopping myself, I choose it myself." A relative said, "He [person that used the service] is happy at Prince Regent. I would say it's a good service. I think they manage his condition as well as can be expected."

Staff undertook an induction programme on commencing work at the service. This included the opportunity to shadow experienced staff for a minimum of five shifts, although the registered manager said this period was sometimes longer depending on the needs of the individual staff member. New staff had completed the Skills for Care Common Induction Standards. The registered manager was aware that this had now been replaced by the Care Certificate. These are qualifications for staff who are new to working in social care.

Staff told us they undertook regular training. This included training about first aid, food safety, safeguarding adults, the use of physical intervention and understanding mental health. Staff told us they were happy with the level of training provided. However, records showed that 13 of the staff working at the service at the time of our inspection had not undertaken training about autism. This was despite the fact that all six people using the service were on the autistic spectrum. The deputy manager told us it was the expectation of the provider that all staff undertake training about autism. We recommend that the provider makes arrangements for all care and management staff working at the service to undertake appropriate training about autism to support them in their role.

Staff told us and records confirmed that they had regular supervision. One staff member said they had formal supervision every two to three months but that they had almost daily discussions with their supervisor. They said they used supervision to discuss their personal development, issues relating to people that used the service and any concerns they had. For example, they said they raised a concern about another member of staff who they felt was not following instructions. They said the manager called a meeting with the relevant staff and the issue was satisfactorily resolved. Another member of staff said, "They tell you where you are going right and wrong in supervision."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the home was meeting the requirements of the MCA and DoLS and found that they were.

Staff told us people were able to make a lot of choices for themselves about their daily lives, for example about what they wore and if they wanted to go out. One staff member told us, "I ask service users what they want to do, give them choices like at breakfast. You have to do that." The care plan for one person stated, "Under no circumstances is [person that used the service] made to go to bed at a time staff feels suits them." The care plan for another person evidenced how the person had been able to choose the curtains in their room. They were shown various different patterns and they were able to pick the one they preferred. However, although we found that support staff were knowledgeable about how to support people to make choices, they had only limited understanding of the legislation and principles of the MCA and this is an area for further development within the service. We did however find that the registered manager and two deputy managers had a good understanding of this area of practice.

We found the service had made appropriate applications to the local authority for those people they had assessed as requiring a DoLS authorisation.

One staff member said people were able to choose their own breakfast and lunch, telling us, "They make individual choices at lunchtime." They said the evening meal was chosen by people but that it tended to be one meal cooked for everyone. The registered manager told us that if people wanted an alternative then that was provided upon request.

One person told us "I cook myself." Another person said, "I am getting enough food. If I am not happy with the food I will start cooking my own." We saw photographs of this person preparing food and their relative confirmed they were able to cook with some support from staff. A relative said, "They are quite varied with the food that they have. Sometimes he [person that used the service] doesn't want what they are cooking so he will cook something else himself."

Records showed people had routine access to health care professionals, including psychiatrists, psychologists, GP's, dentists and chiropodists. One person had been involved in art therapy and records showed this was something they very much valued and found beneficial. However, we saw that some records of medical appointments only included the name of the health care professional seen, not what their particular specialism was. We discussed this with the deputy manager who amended the form used for recording medical appointments to include this information.

The registered manager told us the service had a positive relationship with other care agencies. We saw a complimentary email from one health professional working with the service. The professional wrote, "You seem to be a very proactive team who are developing a good understanding of [person that used the service] behaviour and the most useful ways to support them."

Health Action Plans were in place for people which set out how to support people to be healthy. They included details about healthy lifestyles through diet and exercise and the support from health care professionals people required. Hospital passports were also in place which provided important information about the person to hospital staff in the event the person was admitted to hospital. For example, they included information about people's medical history, medicines they were taking and how best to communicate with them.

Good

Is the service caring?

Our findings

People and relatives told us they were treated in a caring and respectful manner by staff. One person said of the staff, "They are polite."

Two people showed us their bedrooms. We saw these were decorated to their personal taste with family photographs and examples of their own artwork on display. We also saw people's artwork was on display in some of the communal areas of the home. People had their own possessions in their bedrooms such as televisions and DVD players.

Staff were observed to knock and wait for an answer before entering people's rooms. We observed one person opened their door to staff naked and staff were seen to change their body position so they were not looking at the person while they gently encouraged them to put on some clothes. We saw that staff interacted with people in a caring and sensitive manner and people were at ease in the company of staff.

The service sought to promote people's independence. One staff member told us, "We try and give them as much independence as we can." They told us people were supported to visit local shops to purchase items of their choice. Another staff member said one person enjoyed cooking and they supported them to do this themselves, but added that they needed to support the person with chopping ingredients to promote their safety. They said another person was able to dress themselves but sometimes they needed reminding to put clean clothes on. Another member of staff said "I will ask [person that used the service] if he needs any assistance with personal care but will let him do it himself when he can." Care plans included information about promoting people's independence. The care plan for one person stated, "I am able to wash myself independently but I need lots of prompting as this is something I do not like to do." We saw in another care plan evidence of work the service had done to support the person to shop independently by teaching them the value of different coins.

Staff had a good understanding of people's communication needs. For example, one staff member explained how they used basic sign language with one person to support them to make choices, for example about what they wanted to eat. One person did not speak English as a first language and there were staff working at the service that spoke the person's preferred language. The care plan for one person stated, "Staff to use visual material for example pictures to help person make choices." The registered manager told us one of the things they were most proud of at the service was the work done with outside professionals to help to understand people's communication needs. For example, the speech and language therapy team had been working with staff about the best ways to support individual's communication needs. They said this had contributed to a significant reduction in instances of behaviours that challenged the service.

People were supported to maintain contact with their family. Family members were able to visit the service and people went to visit family at their homes. People were also able to maintain contact with family by telephone.

Good

Is the service responsive?

Our findings

People and their relatives told us the service was responsive to their needs. A relative said, "They have put in place things and are prepared to try new things if things don't go to plan." The same relative told us that the service regularly spoke with them about their relative and how to support them. They said, "They do communicate with me and check things about him with me. When we have our review meetings which are regular I give them feedback and they would encourage it, especially on cultural things like how to manage his hair."

The registered manager told us that two senior members of staff carried out assessments of people's needs before they were offered a placement at the service. This involved meeting with the person and their relatives and speaking with professional staff who were involved in the person's care. The purpose of the assessment was to determine if the service was suitable and if it would be able to meet the person's needs. The registered manager told us they had on occasions not offered people a placement at the service as a result of the assessment as they had not considered that it was suitable for the person. The registered manager told us people had a phased move in to the service with the chance to visit on several occasions to help the transition go smoothly.

Care plans were in place for people. The registered manager told us these were initially based on the assessments that had been carried out and were then developed over time based on on-going observation and discussion with people. Care plans covered various topics including social activities, accessing the community and personal care. These set out how to support the individual needs of people in a personalised manner. For example, the care plan for one person stated, "When using public transport ensure it is at quieter times and avoid times when children are likely to travel." Care plans included a one page profile about the most important information. This made it accessible to agency staff that were only working a limited number of shifts at the home to get a basic understanding of people's needs if they did not have time to read the full care plan.

Elements of care plans were made more accessible to people who had needs around literacy. For example, the care plan for one person had a pictorial section about what was important to them and what they wanted in their home.

Care plans were subject to regular review. Each week the person and their keyworker went through their care plan to determine what elements of it were working well or not working well and this fed in to the monthly care plan reviews. This meant care plans were able to reflect people's needs as they changed over time.

Staff told us they were expected to read care plans, one staff member said, "I read care plans when I did my induction to know how to support them [people that used the service]." Staff were knowledgeable about the contents of the care plans for people they worked with.

Staff told us and records confirmed that there was a staff handover at the beginning/end of every shift. This

gave staff the opportunity to discuss any relevant issues regarding people and to update staff coming on duty of any changes in people's needs.

The service had a garden which people were able to access. This had various equipment to support people's activities including a jacuzzi hot tub, swings, a trampoline and a sensory garden. A member of staff told us that people were involved in maintaining the garden during the summer months. We saw one person playing football in the garden with a member of staff. Another person said, "I like to do exercise in the garden and the park." The service also had a sensory room for people to use.

People were able to access various activities in the community. One person said, "I do activities, I go to the library." A relative told us, "Access to the community is 110%. Even if things go wrong staff do a risk assessment and try again. They constantly try to keep him in the community and he really likes that. He talks about going swimming and to the shops." The service had its own transport and on the first day of our inspection a person was supported to go out for a drive, we saw evidence that they were supported to take part in activities they enjoyed including day trips to the seaside and a visit to central London to see the Christmas lights. Another person went to a local park on the day of our inspection and told us they had enjoyed this. Staff told us that community based activities were based around people's preferences and that there were very few group activities within the community. The registered manager said, "We don't do many group activities here because they are all very different." This was in line with our observations during our inspection. The deputy manager told us one person attended a group run by the local authority for people with Asperger's Syndrome where they learnt cooking skills and went on day trips.

People told us they would address complaints with a senior member of staff. A relative told us they had raised a concern with the registered manager and they had dealt with it to their satisfaction.

The provider had a complaints procedure. A pictorial version of this had been designed by people that used the service to help make it more accessible to people. The procedure included timescales for responding to any complaints received. However, it did not include details of the Local government Ombudsman. This is the organisation that has responsibility for investigating complaints in care homes if a complainant is not satisfied with the response they get from the provider. We discussed this with the registered manager who told us they would raise the issue with their manager with a view to getting the procedure amended.

The registered manager told us there had been one complaint received since the service was first registered with the Care Quality Commission. We saw that this had been recorded and investigated appropriately. Details of the action taken were clearly detailed in line with the complaints procedure.

Good

Is the service well-led?

Our findings

People and relatives told us they were happy with the management at the service. One person said, "She [registered manager] is nice. I like her. I think she is a nice lady." A relative told us they had good communication with the registered manager. They said, "I usually communicate by email and they always get back to me."

The service had a registered manager in place who was supported in the running of the service by two deputy managers. There were clear lines of accountability and staff knew who their line manager was.

Staff told us there was an open management culture within the service. Staff said they found the management team to be approachable and accessible. One member of staff said, "I can go to her [their line manager] at any time." The same staff member said, "They [the registered manager and two deputy managers] are all supportive. The manager runs a tight ship but she is fair." Another staff member said, "Our management are good. They are ready to give us any support we need." Another member of staff said, "Management are really great, I can't fault them." Staff said there was a supportive culture amongst the staff team. One staff member said, "The team is family orientated. I was given so much help and support from different staff members who know the people really well."

The service had various quality assurance and monitoring systems in place. Some of these included seeking the views of people that used the service. The registered manager told us that the service did not have group residents meeting due to the nature of the people that used the service. They said instead people had monthly one to one meetings with their keyworkers. We saw minutes of these meetings which showed discussions about maintenance issues, activities and safety. They also discussed any complaints or suggestions the person had which meant the service was being proactive in seeking people's views about were the service could improve.

The registered manager told us that the service carried out six monthly surveys of people that used the service, their relatives, staff and other professionals that worked with the service. We saw the results of the most recent survey. Although these had not been dated the registered manager told us they were from the summer of 2015. These contained mostly positive feedback about the service. For example, one relative wrote, "Very happy about the service given to [person that used the service]." A relative we spoke with told us, "Quite recently they sent a feedback thing for me to fill in." The staff survey contained mixed results and the registered manager told us they had tried to address concerns raised by empowering care staff to take more of a lead in how the service was run. For example, staff had taken over setting the agenda for some of the team meetings so they were able to discuss matters of most importance to them.

The registered manager told us and records confirmed that weekly audits were carried out of people's finances, medicine records, fire safety records and the physical environment. In addition the provider employed an outside agency to carry out audits of the service. Records showed the most recent one was done in July 2015 and looked at risk assessments, support plans, medication and how well the service was meeting the requirements of the Mental Capacity Act 2005.

Another manager from the same provider visited every two months to carry out an audit. The most recent one was conducted on 29 December 2015. Amongst other things this looked at people's care files, safeguarding and complaints. The audit identified that guidelines for administering 'as required' (PRN) medicines had not been agreed with the medical practitioner who had prescribed the medicine. We found the service had arranged to meet with the relevant professional to address this issue. This showed that the service acted to address identified shortfalls.

Staff told us and records confirmed that there were regular staff team meetings. Minutes of staff meetings showed discussions about people that used the service to identify best practice in working with them and to promote a consistent approach amongst the staff team. Staff meetings also included discussions about how things could be improved at the service. For example, there was a discussion about the ineffectiveness of shift handovers and what actions could be taken to improve them. We saw this had been followed up and action had been taken to improve their effectiveness, for example by the introduction of a written summary of the shift that was ending.