Precious Homes Limited

Arthur House

Inspection report

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Date of inspection visit:
17 October 2019
18 October 2019

Date of publication:
24 June 2020

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Arthur House is a residential care home providing personal care to five people who are living with a learning disability at the time of the inspection. The service can support up to six people.

Arthur House also provides a supported living service for six people and in addition offer domiciliary care for people living in their own homes within the community. At the time of the inspection one person was accessing the supported living service who received the regulated activity of personal care.

The service has been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service did not consistently receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

People's experience of using this service and what we found
At this inspection in October 2019 we found serious concerns about the safety of the residential service. People were at risk of and at times had been subjected to unsafe and inadequate care and support. Risks to people relating to the management of people's mental healthcare needs were not always identified, recorded and known to staff. The failure to mitigate against known risks had exposed people to actual harm. Staff lacked knowledge of those at risk of ligature and self-harm and measures were not in place to minimise this risk. People did not live in a safe environment. Environmental risks had not been considered that were associated with ligature, self-harm and arson. People were not safeguarded from abuse as allegations of abuse were not always recognised, investigated or referred to external agencies. Systems for the management of people's medicines had not always ensured they were managed correctly

Pre-assessment processes were inadequate and as a result one person was living at the home whose needs could not be met effectively. Staff had not received the training and support they needed to support people effectively. People told us they were supported to prepare food which they enjoyed. People were supported to access health professionals when needed. Professionals told us their recommendations to improve people's health and well-being were not consistently followed. We saw people were supported to have maximum choice and control of their lives. However, staff did not know how to support people in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice as staff did not know which people were subject to a Deprivation of Liberty Safeguards.

People did not experience kind and compassionate care as we found numerous examples where people had experienced harm and were exposed to the on-going risk of harm. Although we saw individual staff were caring in their approach, the systems and processes implemented by the provider had not always supported staff to display their caring values. People were not always treated with dignity. People's

independence was promoted, and people were supported to maintain friendships and contact with families.

People did not receive responsive care which met their needs. Care plans did not reflect people's current needs, and they were not an accurate or helpful tool for staff providing care. Staff did not know what people's needs were and how support should be provided. Relatives and health professionals that provided feedback raised concerns about the responsiveness of the service. There was no evidence that people and their relatives had been actively encouraged to be involved in discussing or reviewing their own care on a regular basis. People told us who they could go to if they wished to complain or share a concern. Relatives told us whilst they knew how and who to complain to their concerns were not always listened to or acted upon. Care records showed that people and their relatives had not been consistently asked about their wishes at the end of their life.

Serious shortfalls identified at this inspection, had not been identified by the provider's quality assurance system. Management staff had not effectively identified and managed risks and incidents, therefore, people were placed at risk of harm. The provider failed to learn lessons to ensure risks associated with individuals were identified, planned for and monitored effectively. The provider had not acted on their duty of candour and shared information where incidents had occurred.

We received positive feedback from the one person and their relatives who used the supported living service in relation to the care and support they received.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 05 May 2017)

Why we inspected
This was a planned inspection based on the previous rating.

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

Enforcement
We have identified breaches in relation to keeping people safe, responding to allegations of abuse, staffing and monitoring the care provided at this inspection.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This

means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Arthur House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors and one assistant inspector on day one and two and two inspectors on day three.

Service and service type
Arthur House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service also provides care and support to people living in six 'supported living' settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. This service is also a domiciliary care agency. It provides care and support to people living in their own houses and flats.

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
This inspection was announced. We gave the service 24 hours' notice of the inspection. This was because the service is small and people are often out and we wanted to be sure there would be people at home to speak with us.

Inspection activity for the supported living service started on 17 October 2019 and ended on the 17 October

2019. We visited the supported living service office location on the same date. We conducted the residential service inspection over a period of three days.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We reviewed information we had received about the service since the last inspection. We sought feedback from the Local Authority, professionals who work with the service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We met all five people who lived at Arthur House (residential service) and we spoke with four people who used the service about their experiences of the care provided. In addition, we communicated with one person who used the supported living service. We spoke with fourteen members of staff including directors of operations, registered manager, deputy manager and support workers from both the residential and supported living services. In addition, we spoke with a visiting health professional.

We reviewed a range of records across the two services provided. This included five people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service (s), including policies and procedures were reviewed.

After the inspection
Following our inspection, we spoke with three relatives about their experiences of the care provided from the residential service and one relative from the supported living service. We also spoke with two healthcare professionals who regularly visit the residential service. We continued to seek clarification from the provider to validate evidence and to address the concerns we identified.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- Systems had not been established and operated effectively to ensure that people were protected from the risk of abuse.
- Staff did not always recognise incidents of a safeguarding nature and not all safeguarding allegations had been escalated to the appropriate authorities. We had to prompt the service to make four referrals to the local safeguarding authority. We received the retrospective notifications following our inspection.
- Processes to learn lessons when incidents or mistakes happened were not embedded within the culture of the staff team. Where incidents had occurred within the service, these had not all been documented within incident records. For example, on day three of our inspection we saw in one person's daily notes that they had experienced harm by self-harming. This had not been considered as a serious incident, it had not been reported to the management team and it had not been escalated to the relevant local safeguarding authorities.
- The service had failed to recognise risks following incidents and had further failed to then mitigate against the likelihood of further incidents. De-briefing sessions with staff following incidents which could be used as a valuable opportunity to learn lessons were not consistent. Processes to learn lessons when incidents or mistakes happened were not embedded within the culture of the staff team and this was demonstrated by repeated incidents of self-harm.

The lack of systems to identify, report and investigate allegations had left people exposed to potential abuse and meant people were at significant risk of harm. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Assessing risk, safety monitoring and management; Using medicines safely

- Effective systems were not in place to ensure risks were monitored and managed in order to protect people from avoidable harm. We identified serious concerns around the registered provider's ability to effectively assess and manage the risks to some people living at Arthur House.
- Known risks to people's safety had not been adequately assessed and mitigated against. During the first two days of inspection, we identified a number of key risks to people that had not been considered or recorded adequately within care records. This included risk of self-harm, suicide and arson.
- Assessments to identify these risks were either insufficiently detailed to guide staff about how to support people to mitigate risks, or where information was provided, this was not being followed by staff. For example, one person's risk assessment dated November 2018 identified that they were to be monitored in relation to having access to sharp instruments. However, we found an incident form where the person had self-harmed with the use of their razor in July 2019. This was evidence that this risk was not being effectively managed and as a result the person experienced harm.

● We found historic assessment records relating to people identifying the risk of self-harm and environmental safety. Risk assessments did not outline how staff should protect people from these known risks and care staff were not able to describe to us how they would keep people safe from associated harm.

●We found people's care plans and risk assessments in respect of people's mental health needs were poorly documented and the management of people's behaviours did not ensure that people were safe. The registered provider had failed to ensure staff had sufficient understanding of how to monitor and support people with these complex needs.

● During our inspection we saw garden tools left unsecured in the garden area. We brought these to the immediate attention of the registered manager as these posed a risk to people who live at the home and asked for them to be removed. Environmental risk assessments in place had failed to identify and adequately assess and manage these risks.

●The provider had failed to assess potential and associated risks within the premises including ligature points [objects which people could use to hang themselves] and had failed to help mitigate against known risks of a person who lived at Arthur House including previous suicide attempts by hanging.

●During discussions on 17 and 18 October 2019, the registered provider had failed to recognise the immediate ligature risks and how to mitigate against the safety of the premises.

● As a result of our concerns we took immediate urgent enforcement action. We returned to the service for a third day to check that the urgent action required to keep people safe had been put into place. Whilst we saw that the provider had started to implement new risk assessments that would identify the key risks to people's safety, the assessments in place continued to lack robust detail about the risks posed to people and how these should be managed.

● We found the provider had failed to complete actions outlined in the urgent enforcement. They had failed to ensure that people were protected from the ongoing risk of immediate harm. As a result, one person had experienced harm and the ongoing risk of serious, immediate harm had continued.

●Anti-ligature equipment had been ordered and delivered to the residential service on Friday 25 October 2019. These had not been fitted by the third day of our inspection on 29 October 2019 and were still in their packaging in the office. This meant that one person who lived at the home was exposed to continued and immediate risk of ligature.

●In addition, we also saw and brought to the registered managers attention, potentially hazardous substances on the premises. Hazardous items included bleach, disinfectant, polish and cleaning products in the laundry area of the home. This was of particular concern given the sign displayed on the front of the laundry door instructed staff to keep the laundry locked at all times. We found the door to be unlocked and was accessible for all people who lived at Arthur House. The provider, registered manager and staff had failed to consider these additional risks posed within the premises and to ensure they were appropriately assessed and mitigated against to keep all people protected from harm.

● One relative told us their loved one was not always safe and told us staff allowed their relative out without a mobile phone and said, "[name of person] needs a phone for their safety." Another relative told us of an incident which had occurred when one person had thrown something at their relative and said, "[name of relative] kept flinching, I wasn't told about the incident straight away."

●People did not always receive their medicines as prescribed. Medicines were not always received, stored, administered and disposed of safely. On the first day of the inspection we found a supermarket carrier bag containing medicines for a person in a locked cupboard. The morning, lunch, afternoon and night blister pack sleeves were mixed up together. We also found non-prescribed pain killers in the carrier bag. The lack of robust storage systems placed the person at risk of not receiving the right medicines at the right time.

● The registered provider, registered manager and staff had failed to ensure that risks associated with medical conditions including allergies were mitigated against. One person's support plan identified they had a serious nut allergy that required them to have two EpiPen's (lifesaving injection) on their person at all times. The person's Medicine Administration Record stated a second epi-pen application is to be

administered within five to fifteen minutes if the first one does not work. The inspectors observed the person went out in the community with staff for three hours on 17 October 2019 with only one epi-pen. Care staff were unaware of the immediate and serious risk they had exposed the person to.

● We found that a liquid medicine had not been dated with a date of opening, this meant that staff did not know what date the medicine was no longer safe to use.

● The administration of 'when required' medicines were not always recorded correctly. The strength of medicine given and the reason for administration was not always documented on the drug administration record or in people's daily notes.

● It was not always clear if medicines with special instructions had been administered correctly. For example, one person's medicines were prescribed to be administered one hour after food. However, from the person's medication administration record and daily notes, it was not clear how this was being carried out or monitored.

Inadequate risk management and medicine systems meant that risks to people could not be consistently managed and left people at risk of harm. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

●People we spoke with generally felt safe. One person told us, "I feel very very safe living here."

● Staff we spoke with were aware of the risks to the person who used the supported living service. A relative we spoke with whose loved one used the supported living service told us, "[name of person] is safe and well-cared for."

Staffing and recruitment

● People's views on staffing levels varied. One person said, "Staff are here every day." One relative told us, "Some weekends can be lacking staff, when agency staff go in they are useless and don't know people's needs."

● All the staff we spoke with told us there were enough staff to meet people's needs. Our observations on the days of the inspection confirmed that staff were available to support people when required.

● The registered manager advised that people's dependency levels were reviewed and calculated regularly.

●Staff had been recruited safely. All required pre-employment checks had been carried out including criminal record checks and getting references from previous employers.

Preventing and controlling infection

● People were protected from the risks of infection by staff's practice. We saw staff followed infection control practices and used personal protective equipment, such as gloves and aprons, to help prevent the spread of infection. On the days of the inspection the home appeared clean and hygienic.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet people's needs

●Assessments of people's needs had been completed prior to them moving into the home. However, historic information about one person had not been considered as part of the pre-assessment of the person's care needs which included staffing needs and their environment. We saw records available to the service prior to the person's admission outlined a history of self-harm, arson, suicidal ideation and attempted suicide.

●Effective risk assessments were not in place that outlined how staff should mitigate against the known risks to this person and staff we spoke with did not understand how to safely manage the risk.

●These known behaviours represented a risk to the person and other people who lived at Arthur House. As a result of the poor assessment process, the provider had potentially moved people into the home whose needs they could not meet. This was confirmed to us by the nominated individual.

● The nominated individual shared their new assessment tool with us that would improve the quality of the information gathered during assessments to enable the provider to make safer admission decisions. However, they had not yet had opportunity to test out their new assessment process.

●The service had not adapted the residential care home premises to keep people safe.

● The management team had completed an environmental risk assessment to assess the risks in relation to the building. They had not considered or identified ligature risks or taken the necessary measures to ensure people were safe and the safety of the environment. At the time of the publication of this report, there were no longer any people living at the service who were at risk of harm from ligatures.

Inadequate pre-assessment processes and poor risk management placed people at risk of harm. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

●A relative of the one person who used the supported living service told us, "[name of person] previous placement broke down so there was no transition period. I have given the staff what they need to know and how to care for him. The staff have really persevered, and they love him to bits."

Staff support: induction, training, skills and experience

●The current training completion level by staff at the service did not meet the required compliance standard set by the provider. For example, there were gaps in fresher training around moving & handling and safeguarding training.

●People using the service had a learning disability and autism with associated complex mental health

needs. Despite failings and safeguarding incidents occurring within the service, the staff had not received relevant training to promote a supportive safe, and positive approach for people. For example, staff were not provided with safety-related training in subjects such as self-harming and ligature to support people to be safe.

●Following the first two days of inspection, the provider submitted an action plan that detailed their intention to deliver workshops to staff in areas including, self-harm to address the areas of concern identified at this inspection.

●An effective system was not in place to undertake regular observations of staff competencies to ensure staff were putting their learning into place. The director of operations advised us they were going to implement more staff observations following the inspection.

The registered provider had failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet people's care and treatment needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

● People told us that where they required healthcare input, for example from their GP, that this would be sought for them. One person told us, "If I'm poorly I go to the doctors."

●We received mixed comments from relatives we spoke with. One relative told us, "[name of relative] attends all their health appointments there is never a problem with those." However, other comments included, "[name of relative] missed a few medical appointments because staff had not checked the appointments book. I have to remind them about everything all of the time." Another relative said, "I have to keep reminding staff to check [name of relative] if they have [been to the toilet], they don't monitor it enough." Records showed that some people had received visits from other healthcare professionals including community mental health nurses.

● People had additional support from specialist health care professionals. For example, psychologists, occupational therapists, and others.

●Guidance drawn up by these professionals was not consistently incorporated into people`s care plans and often not used by staff. For example, one professional told us they monitor medicine forms and on their arrival to the home the form would not be completed or it would be incorrectly completed, despite each week explaining what needed to be included and said, " I have had occasions where staff have advised me an individual has not opened bowels for 4 days, but the chart states they have opened their bowels at least once a day.

● Another professional told us, "I have made numerous recommendations to staff how to support a person with their engagement and sensory needs. They say they will do it, but there is no evidence. The recommendations had not been incorporated in the person`s daily support plan.

● In addition, we spoke with a relative in respect of staff who supported their relation with engagement and sensory support. They agreed with the professional's feedback and explained the importance of their relative undertaking engagement and sensory activities and said, "My relative was in their bedroom and crying with boredom. Staff told me they had not left the house because they were short staffed. She needs regular stimulation and is not getting it." Following the inspection, the registered manager advised that they were not short staffed, however there had been times that drivers had not been available.

● Some of the professionals we spoke with were more positive. One professional told us, "I have noticed improvements in the past few weeks. Staff have been prepared when I arrive and also the charts I request have been completed. The individual's keyworker has also been brilliant at implementing what I recommend."

● A relative of a person who used the supported living service told us, "[name of person] attends all their

hospital and medical appointments."

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink enough. All the people we spoke with told us which foods they enjoyed. One person said, "I always choose what I want to eat, my favourite is Lasagne."
● However, some relatives described less positive comments. One relative said, "[name of person] has a very poor diet, they have put on weight which has affected their health and mobility." Another relative said, "[name of person] food shopping is disgusting. They don't get proper meals and only buy value products."
● Staff we spoke with described how important it was to involve people in choices about the food they wanted. One staff member told us, "We create individual menu plans with people and they tell us what they want."
● Records we looked at confirmed people had their preferred meal choices and were offered a varied diet. However, a relative told us their loved one's cultural dietary needs were not met and told us, "I don't mind so much as I take their meat in now."
● Care plans we sampled listed people's likes and dislikes in relation to food and drink and any specific dietary, cultural or religious requirements.
● A relative of the one person who used the supported living service told us, "[name of person] gets the food they like, I see their meal plans every week, so I know what they are eating."

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. Where the service is currently depriving a person of their liberty, whether under a Deprivation of Liberty Safeguards (DoLS) authorisation or under authorisations from the Court of Protection.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● We observed staff gaining consent from people before supporting them with their needs. For example, asking people what they wanted to do. One member of staff told us, "The MCA supports people to make decisions for themselves or in their best interests if they can't."
● A relative of a person who used the supported living service told us, "Staff know [name of person] non-verbal communication and how to respond to them."
●The majority of the staff we spoke with did not always know which people were subject to authorised DoLS and lacked knowledge and understanding about DoLS and what it meant for people who lived at the home. One staff member told us, "No-one here has a DoLS." Another staff member told us only one person had a DoLS. The registered manager advised us everyone living in the residential home was subject to a DoLS authorisation. Whilst we did not see this had immediately impacted on people's care and support, the registered provider had not worked with the staff team to make sure they understood who was legally

authorised under DoLS. In addition, whilst people had the appropriate authorisations in place the provider had not developed care plans to demonstrate how they were considering and applying the least restrictive care practices when supporting people.

Inadequate

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.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

- People did not experience kind and compassionate care and we found numerous examples where people had experienced harm and were exposed to the on-going risk of harm.
- We found some people's mental or emotional health needs had not been adequately addressed or recognised. This has been reflected throughout the report. Due to the concerns identified during the inspection, the provider could not be assured that people received a high-quality caring and compassionate service.
- Although we saw individual staff were caring in their approach and spoke positively about the people they supported, the systems and processes implemented by the provider had not always supported staff to display their caring values. Staff did not have all the information and support they needed to care for people adequately and as a result people experienced poor outcomes.
- During the second day of the inspection we found three obvious ligature risks in the small communal lounge area. The registered manager believed these had been deliberately left in the area by staff to get the organisation into trouble with CQC. This exposed the risk of immediate, ongoing and avoidable harm to one person who lived at the home. Several staff were disciplined after the inspection due to concerns regarding their practice. This did not demonstrate a caring environment.
- During the inspection we observed one person who displayed distressed behaviour during the handover period. A member of staff told us it was normal behaviour for the person during this time. The staff had not been responsive to the person's needs or considered alternative methods for handover to reduce this person's anxieties.

Inadequate pre-assessment processes and poor risk management placed people at risk of harm. This resulted in poor outcomes for people. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

- Despite our concerns with the consistency of the staff approach we did hear some people felt staff respected them and were kind and caring. One person told us, "I like [name of staff]."
- A relative of the one person who used the supported living service told us, "[name of person] dad turned up unannounced to visit him and said [name of person] was looking nice and smart."

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was not consistently respected and promoted. Although staff we spoke with were aware of how to promote people's dignity, this had not been consistently practiced.

● One relative told us that their loved one never has the right clothes in their wardrobe and said, "They are always giving him ones from other people. I tell them over and over, but they [staff] just don't listen."
● Whilst staff told us they respected people's right to confidentiality this did not consistently happen in practice. We saw a staff handover being carried out in a communal area whilst other people were using it. Confidential and personal information pertaining to people was discussed which could be heard by other people who lived at the home and or visited.
● We saw staff promoting people's independence. Staff supported one person to improve their daily living skills by practising their baking skills in the kitchen. Other people were being supported to become more independent in the community and go out without staff support.
● People were supported to maintain links with those closest to them. One person told us how much they enjoyed visiting their relatives.
● People's rooms were personalised. People had their own furniture and personal possessions such as paintings, ornaments and objects.
● A relative of the one person who used the supported living service told us, "Staff offer [name of person] privacy and dignity and keep them covered up when [supporting them with personal care needs]."

Supporting people to express their views and be involved in making decisions about their care
● One person told us, "I go to bed when I'm tired and get up when I want to." A relative told us, "They do ask [name of person] their opinions." Meetings took place with people living at the home which gave them opportunity to speak with staff about activities they would like to take part in that day.
●People's views were sought through day to day interactions, and we observed staff communicating with people well. When staff interacted with people, they appeared at ease and enjoyed the company of staff.
● A relative of the one person who used the supported living service told us, "I'm involved in the planning of [name of person] care and included in all the reviews."

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Meeting people's communication needs

●Care was not always responsive to people's needs. We found assessments of people's needs were not always in place. Due to the concerns identified during the inspection, the provider could not be assured people received a responsive service.

● One relative we spoke with told us the service was not responsive to the needs of their relative and told us, "Staff forget that [name of person] is a person and don't think outside the box to engage them in things."

● Another relative told us staff were not proactive in finding things for their relative to do and said, "I have had to research everything [name of person] does and I have found things for them to do."

● Healthcare professionals that provided feedback raised concerns about the responsiveness of the service in relation to the provision of engagement and sensory stimulation. They told us that the support towards achieving goals for people had been inconsistent to support people in achieving their goals.

●Staff were not always responsive with managing triggers for people's behaviours. For example, one person's support plan stated a trigger for their anxieties was the Police visiting their home. Records we reviewed told us that on three recent occasions the Police had recently visited Arthur House. Some staff we spoke were not aware that visiting Police were a trigger for the person's anxieties.

●People's care plans were reviewed regularly, but these reviews were not meaningful. There was no evidence that people and their relatives had been actively encouraged to be involved in discussing or reviewing their own care on a regular basis. One relative told us, "I don't get invited to meetings, issues I raise just get passed over." Another relative told us, "I've never seen [name of person] care plan, I only go to meetings if I request them."

● Some of the assessments of people's needs did not include information about people's life history, culture, religion, sexual orientation and other preferences which would enable the service to deliver more personalised care under the Equality Act.

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● A relative told us staff were not responsive with their relative's communication needs and told us, "Staff forget to use [name of person] communication book and I've taken in folders with word symbols for staff to use to help my relative and staff to communicate and it's not used." ●Following the inspection, the registered manager advised they had developed an action plan to address communication needs for this person and would be sharing this with staff. In addition, the registered manager advised us they were

working with other professionals to produce communication cards.

Some people who did not have complex needs were provided with care and support in line with their individual needs and preferences. However, for people with more complex needs, the provider had failed to ensure that the care and treatment of people was appropriate, met their needs and reflect their preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

●We spoke with staff about what the Equality Act meant for people who lived at the home and if people's needs based on their protected equality characteristics or their values and beliefs were recognised and met. One member of staff told us, "I just respect everyone is different, like different religions and different cultures."
● We saw times when people did receive some personalised care. For example, we saw people were supported with developing individualised menus and social activities. People ate different meals at different times in-line with their wishes. People told us that they had access to activities that met their interests. One person told us, "I enjoy going to the café to work and meet people."
● A relative of the one person who used the supported living service told us they felt the service was responsive to their relatives needs and told us, "[staff] meet [name of person] cultural needs in that there is a lady who cooks Caribbean foods and [name of person] enjoys this."

Improving care quality in response to complaints or concerns
● People told us who they could go to if they wished to complain or share a concern. One person told us, "I would tell [name of registered manager] if I was sad."
●A complaints policy and procedure were in place for people to access and was available in an easy read format. However, it was not prominently positioned within the home.
● Three relatives told us whilst they knew how and who to complain to their concerns were not always listened to or acted upon. One relative told us, "I had some complaints, but they were only resolved when I took my son to a meeting and he sorted it out."
● We saw complaints were logged. In each case there was a timely response and complainants were happy with the outcome.
●A relative of the one person who used the supported living service told us, "The manager is responsive if I need to speak to her, but I would go above her head if I needed to and I keep CQC's number in my phone, but I've not needed it."

End of life care and support
● No-one at the service required end of life care. Care records showed that people and their relatives had not been consistently asked about their wishes at the end of their life. This meant that should the person become unwell or pass suddenly, the provider would not have any information about the person's wishes to ensure these would be respected.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● There were inadequate systems in place to monitor the quality and safety of service provided and the provider had failed to ensure people received the care and support they needed. As a result, people experienced and were exposed to on-going risk of harm. There were widespread and systematic failings in the way the service was led and the governance in place did not assure delivery of high quality and safe care.

●There were inadequate safeguarding systems in place. The provider had failed to escalate safeguarding matters and other incidents to relevant partner agencies to protect people at all times. We found people were placed at risk of harm as staff did not understand, report or recognise potential safeguarding concerns. As a result, people experienced and were exposed to on-going risk of harm.

● We wrote to the registered provider following the second day of inspection to outline our continued concerns because the evidence suggested the risks to the service and people safety had not been mitigated. Despite highlighting the concerns, the provider had failed to fully address the risks when we returned for our third day of inspection; despite the provider giving assurances that they had addressed all the risks and people were safe. Responsive action had not been taken in all areas and we remained concerned about the capability of the registered provider to drive forward the improvements needed because they did not appear to fully aware of the risks in place.

● Pre-admissions and risk assessment processes were inadequate. During our inspection we had to advise the provider about the significant ligature risks, self-harm and arson risks to some people living at the home. During the inspection, and as part of the urgent enforcement action we had taken, the nominated individual sent us an action plan to address our concerns. The action plan stated 'Our assessment process for one person has clearly failed to identify that we could not meet their needs. We should not have admitted [the person] to the service. Notice has been served [to the local authority].' At the time this report was published the person no longer lived at Arthur House.

●The systems in place to ensure the management team were made aware of significant incidents that had occurred were inadequate. We saw on the third day of our inspection that incidents of self-harming had occurred and had not been brought to the attention of the management team.

●We found incident auditing systems were not effective as incidents were not always being reported by staff. The incidents were not fed into auditing and monitoring systems. The provider had not taken sufficient action to review situations surrounding incidents and had not taken sufficient action to ensure staff could protect people as far as possible from any future events. This had led to allegations of abuse not being acted upon, and key information about how to keep people safe being left out of care records.

●The provider had failed to develop policies and protocols related to ligatures and self-harm to set out what is required to mitigate against known risks. This exposed people and others to the risk of immediate, ongoing and avoidable harm.
● There was a range of audits in operation to monitor the health, safety and welfare of people who used the service. However, these had not been effective and had failed in identifying the concerns identified at this inspection.
● There were no systems in place that gave the provider continual oversight of emerging concerns or risks in the service.
● Systems for managing staff training was ineffective. Support for staff learning and development was insufficient. Staff had not received the training they needed to give them the skills to support people safely and in line with best practice. The provider told us following the inspection they had arranged training for staff around self-harm and ligatures.
● The provider had not ensured that governance systems around the administration of medicines were effective and robust. We reviewed the providers medicine audits and they had not identified the shortfalls found during the inspection. As a result, errors had not been identified and sufficiently addressed meaning people were exposed to the risk of avoidable harm. The systems in place for the storage of medicines had been ineffective as some medications were not stored safely.
●There were no effective systems to monitor compliance with the Mental Capacity Act 2005. For example, the majority of the staff we spoke with during our inspection did not always know which people were subject to authorised Deprivation of Liberty Safeguards (DoLS) and lacked knowledge and understanding about DoLS and what it meant for people who lived at the home.
●The registered provider had failed to ensure all records and documentation were kept accurately and up to date, ensuring that a full and complete, contemporaneous record of people's care is in place.
●We identified multiple issues where people's records were not kept up to date and accurately. For example; staff had recorded on one person's daily records that they were not showing signs of distress. However, the person's medicine records for the same day stated the person had been administered 'as and when needed' medicine (Lorazepam) to reduce their distress.
●The registered providers systems and processes had failed to ensure all people received consistent person-centred, good outcomes, dignified and respectful high-quality care.

The provider had not ensured that their systems and processes were effective in enabling staff to provide safe and good quality care for people. The lack of oversight of the service had left people at risk of harm. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The provider had not ensured a positive culture within the service that achieved good outcomes for people. The ineffective initial assessment process meant that one person's full needs were not always known prior to them moving into the home and resulted in staff being unable to meet people's care needs.
● Relatives and health professionals told us that the residential care service was not consistently responsive to people's needs.
● Relatives from the residential service told us, and records corroborated that they were not consistently involved with the planning and reviewing of care plans.
● A relative of the one person who used the supported living service told us, "[name of person] is happy living here which makes me happy."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider had not acted on their duty of candour. While staff had recorded some incidents, these had not been followed up or shared with the local authority and CQC. The lack of action in response to incidents and concerns left people at risk of harm.
●We continued to have concerns about the provider's oversight and the management of the service. Insufficient action was taken to fully address concerns, continuously learn and drive improvement.
● Although the provider undertook a review of all incidents following the inspection, they had not implemented systems prior to this to ensure that where something goes wrong, they were open and transparent about these.
●The provider had not notified CQC of all safeguarding incidents in line with legal requirements. These omissions meant CQC did not have oversight of all safeguarding allegations to make sure that appropriate action had been taken.

The failure to inform CQC of notifiable events is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notification of other incidents. This is being followed up outside of the inspection process and we will report on any action once it is complete.

●It is a legal requirement that a service's latest Care Quality Commission inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. The registered provider had conspicuously displayed their rating in the home and on their website.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care
● The provider had not acted on feedback given to learn and improve the quality of care provided. Relatives informed us that they had shared feedback with the provider about their concerns about the service and these had not been fully addressed. One relative told us, "There is no consistency and poor leadership, I battle to get each manager to share information about my relative which is awful as [they] have very complex needs."
●There was no current strategy in place to share learning and strive to improve the service. There was no effective approach to monitoring, reviewing or plans in place to evidence any progress in improving the quality of the service.
●People had been involved in regular meetings with staff in which they could discuss the service and what activities they would like. One person told us, "I tell the staff what I would like to do."
●The staff we spoke with said they felt able to raise any issues with the registered manager or seniors and were aware of how to 'whistle-blow'. A 'whistle-blower' is a person who informs on a person or organisation who may be regarded as engaging in an unlawful or immoral activity.
● Staff we spoke with spoke positively about the registered manager. One staff member told us, "[name of registered manager] is trying hard to make improvements."

Working in partnership with others
● The quality assurance systems were limited in their effectiveness to ensure continuous improvement. We identified widespread failings in several areas which should have been addressed through the operation of robust systems of governance, audit and monitoring.
● The service did work in partnership with other professionals and agencies to help meet people's needs. However, health professionals told us their recommendations to enhance people's health and well-being were not always followed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify us of incidents as required by law.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had failed to ensure that the care and treatment of people was appropriate, met their needs and reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The lack of systems to identify, report and investigate allegations had left people exposed to potential abuse and meant people were at significant risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have robust and adequate systems in place to monitor the quality of the service. The provider did not have effective systems in place to assess and monitor risks relating to the

health, safety and welfare of people using the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there was sufficient numbers of suitably skilled and experienced staff to meet people's care needs.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from harm due to inadequate risk management processes within the service. People were not protected from harm by the safe management of medicines.

The enforcement action we took:

We imposed urgent conditions on the provider's registration.