Care Quality Commission

Precious Homes Limited

Arthur House

Inspection report

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Date of inspection visit: 11 November 2014
Date of publication: 30/03/2015

Ratings

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

Overall summary

The inspection took place on 11 November 2014 and was unannounced. This was the home's first inspection since it was registered in January 2014.

The home provides accommodation and care for six people with learning disabilities who may also have autistic spectrum disorders. At the time of the inspection there were three people living in the home.

There was a registered manager in post. 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.

However, the registered manager for the service at the time of the inspection was also managing the setting up of two of the provider's other new services. Interim managers were appointed to manage Arthur House and one of the other new services and at times other staff had to manage the service when these interim arrangements failed.

Summary of findings

The changes in management had led to failings in how the home was managed. People were at risk of harm because there was a lack of clarity about the systems for referring and recording of safeguarding incidents. Safeguarding referrals to the local safeguarding authority were incomplete and did not always contain the information required to protect people from immediate harm.

Staff, a relative and health professionals had raised concerns with staff and managers and felt their concerns and / or advice were not listened to and acted upon. This had resulted in some inconsistencies in how risks to people were managed. For example, some people's care had not been planned in a way to lessen their anxieties; this not happened despite requests from health professionals. Where people's levels of anxiety had resulted in incidents these were not consistently recorded and had not been monitored so that plans could be adjusted. Staff did not have consistent advice how to manage these incidents. Some of these incidents should have been reported to us and had not been. Systems of monitoring risks to people were not in place to lessen the risks to them.

The provider's audit in October 2014 showed that that the management had not ensured that staff had been given appropriate induction, training and supervision to meet the needs of people who lived in the home. Staff and health professionals had concerns about the turnover of staff and whilst agency staff were used this increased the risk of people receiving care from staff who did know or respond appropriately to their complex needs.

We found in a person's record information that a person did not have showers on two occasions as there were no clean towels available. We looked at the reasons for this and found that people who lived in the home and staff had not been protected from the risk of getting an infection. The home's washing machine had been unavailable for several weeks and soiled laundry was being stored in a room which was also used to store frozen food. Unwanted and stained mattresses were being stored in rooms used for training posing health risks for staff. Clinical waste, that could attract vermin, had not been put in the locked clinical waste bins. The maintenance of the cleanliness of the home needed to improve.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

We spoke with two of the three people who lived in the home and they told us they were happy with the support they were receiving and that they chose and enjoyed the meals they had. They were supported to be involved in preparation of food and / or drinks but there was not enough information about healthy eating available. They told us that staff were kind, treated them like adults and they were listened to. People said they were supported to have contact with relatives and be involved in any interests.

We saw that staff interactions with people were kind and that there were enough staff available to support people. There was a clear process of helping people understand the decisions they were making where this was possible and to act in people's best interests where this was not possible. Staff did not start work unless checks said that were safe to work in residential care.

Since the provider's quality assessment in October 2014 there had been improvements in how medicines were administered, plans had been made to improve the level of staff supervision and training.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

Although people said they felt safe they were at risk of infection due to poor infection control practices.

Arrangements for the identification and referral of safeguarding concerns were not clear and incidents where people could be hurt were not managed consistently.

People were supported by staff who had the appropriate checks before starting work and there were sufficient staff to meet people's needs.

Medication was given appropriately but improvement was needed to ensure that any errors were identified quickly.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Staff had not received up-to-date training, induction and support which meant people were at risk from staff who did not have the skills and knowledge to meet their needs.

There was inconsistent planning of health care and the provider did not consistently seek guidance from health care professionals about how to maintain people's well-being.

People were supported to make decisions and supported to eat and drink enough to maintain their health.

Is the service caring?

Good

The service was caring.

People were happy with the support they received. We saw good and kind interactions between staff and people who lived in the home.

People were involved in planning the support they received if they were able and were supported to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not responsive to people's needs.

People who lived in the home told us that they could speak to staff, they were listened to and staff would respond.

Although we knew there had been complaints and concerns about the service complaint records could not be found and this meant that concerns were repeated.

Summary of findings

Arrangements were made for people to participate in individualised interests however these were not always managed consistently.

Is the service well-led?

Requires Improvement

The service was not well led.

There had been different staff managing the home and management was stretched managing two of the provider's other new services.

There was a lack of monitoring and planning to ensure that concerns were responded to and acted upon appropriately, risks to people were minimised and that staff were supplied with the knowledge skills and supervision to support people who lived in the home.

Important people in the lives of people who live in the home did not have their concerns acted upon in a timely way leading to people being unsettled.

Arthur 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 on 11 November 2014 and was unannounced. There were two inspectors involved in the inspection of this home. This was the first inspection of the home since their registration in January 2014.

Before the inspection, 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.

Before our inspection we looked at the information we held about the service. This included notifications received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law.

During the inspection we spoke with two of the three people who lived in the home. We observed the care of people and spoke with one person's relative. We spoke with three health and social care professionals who were visiting people who lived in the home. We spoke with six staff, the registered manager (who was intending to cancel their registration) and a recently recruited replacement manager.

We looked at records relating to the administration of medicines, the recruitment of three staff, the care of two people, complaints and quality assurance. In addition due to concerns raised we looked at the provider's arrangements for infection control.

Requires Improvement

Is the service safe?

Our findings

The two people we spoke with told us they were supported to do day to day tasks including washing of their clothes. A visitor told us that they had concerns because their relative's bedding had gone missing. We found a record that that a person had not received appropriate support with their personal care because there had been no clean towels to dry them. We looked at the reasons for this and how the risk of the spread of infection was managed. Staff told us and we saw that the home's washing machine had been disconnected and were told that it had been so for several weeks.

We found that although staff had been going to a local laundrette, bags of soiled laundry were being stored in two rooms, one of which had a freezer containing food for people living in the home. This meant that people were at an increased risk of acquiring an infection. Two soiled mattresses that were waiting to be collected for destruction were in rooms which staff used to familiarise themselves with some of the home's documents; this resulted in an unpleasant odour in the room and again posed health risks. We saw that a clinical waste bag had been left on top of an external locked clinical waste bin and this could attract vermin. Arrangements were not in place to manage soiled laundry in a timely way and store or dispose of infected waste materials.

The washing machine was made useable on the day of the inspection although the provider had not had plans in place to do this.

Staff we spoke with told us that the supply of antibacterial gels, clean tea towels and aprons had run out when food was being prepared. Care staff supported people with the preparation of food, laundry and cleaning where people were able and undertook these tasks if they were not. We noted that this had already been brought to the provider's attention during their investigation of a safeguarding complaint in June 2014. We saw that cleanliness of some of areas of the home such as the carpets and cleaning of walls had not been maintained to a high enough standard. Therefore the provider did not have robust arrangements for keeping the service clean and hygienic to ensure people were protected from acquiring an infection.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We spoke with two people who lived in the home they told us that they felt safe in the home although one person thought at times it was difficult for staff to manage when people became distressed. At these times they thought other people who lived in the home and staff felt less safe. A relative and health professionals told us that they thought people were safe.

The home's reporting of safeguarding concerns was not clear. Although we had received notifications of safeguarding incidents it was not clear if these were about Arthur House or another of the provider's services. Safeguarding referrals to the local authority and us were sometimes incomplete and did not always contain the information required to protect people from immediate harm. This caused delays and confusion when contacting other agencies involved in safeguarding and there was a risk that people would not receive support in a timely way. Records showed that there had been some continuing incidents of concern, some serious enough for the police to be called however not all of these incidents had been fully recorded or monitored. A member of staff we had spoken with told us that they had been given conflicting information about whether the police was to be called during incidents of behaviour that could be challenging. Although systems were in place these were not consistently applied and were not robust enough to ensure that risks could be minimised.

People who lived in the home told us that they had been involved in the recruitment interviews of staff; this helped people feel involved in the running of the home. Staff told us that they had been interviewed and checks had been made before they were employed and records we looked at confirmed this. Staff were checked before they started working and this helped to keep people safe from harm.

People told us and our observations showed that there were staff available when people needed support. The provider's quality audit, health care professionals we spoke with and some staff we spoke with told us that there was a high turnover of inexperienced staff. One health care staff told us that this had meant they had to repeat instructions to staff and managers about how individual people's care was to be managed but still found the care to be unstructured. Another told us that they had arranged to visit the service at a time when a specific member of staff was available to speak with them about a person's care. On both occasions the staff member was not on duty delaying

Requires Improvement

Is the service safe?

when appropriate plans could be put into place. People who had complex needs were not receiving the consistent support they needed to lessen their anxieties and incidents that were challenging to other people who lived in the home and to staff. This had resulted in occasions where the police had to be called.

We observed two staff supporting people with their morning medicines. We saw that staff spoke to people about their medicines, offered appropriate drinks and ensured that the medicine was taken. We saw the provider's quality audit of the medicines undertaken three weeks prior to our inspection. This identified some concerns about the administration of medicines in the home which included the storage of medicines, some staff had not received appropriate training in medicine administration and some errors had been identified. Records showed that the provider took action when concerns about the administration of medicines were identified. We found the process of ordering, storing and returning unused medicines was safe and comprehensive. Medicines were reordered in a timely manner so people were not left without their prescribed medicines. Medicines were kept securely and additional safeguards were put in place if they were required. Medicines were kept at an appropriate temperature to maintain their effectiveness.

Some staff we spoke with had not completed training in safe administration of medicines. Although staff had to successfully complete some competency checks until this training was undertaken helping to ensure that medicine administration was safer. On the day of the inspection we found that there had been an error in recording a medicine that had not been found by the routine checks of medicines and a person did not receive their prescribed medicinal cream. This indicated that checks on medicines whilst improving were not always robust enough to find errors and omissions quickly.

Requires Improvement

Is the service effective?

Our findings

Although the people we spoke with told us that staff knew how to support them some of the staff we spoke with told us that they did not feel confident that they or, other staff working in the home had the training and skills needed to meet the complex needs of people who lived in the home. The provider's audit of October 2014 indicated that 'a lot of staff are yet to receive key training.' Health and social care professionals we spoke with told us that the training of staff was ineffective in meeting the needs of the people they were involved with. They told us that staff had not acted consistently upon advice they had been given about the support and treatment of people and this had resulted in some people being more unsettled.

Records of staff meetings and staff surveys completed in June 2014 showed that staff had not received regular supportive supervision meetings to discuss their training needs and the care of people who lived in the home. The provider's audit in October 2014 showed that some staff still did not have regular supervision. Some staff had not received the expected induction or important training to meet the needs of people living in the home in the first few weeks of commencing work.

There were signs of some very recent improvement in the planning of training and supervision. Staff told us that the recently recruited manager was talking with them and that there had been improvements in communication. We saw schedules for planned training displayed and the home's communication diary had details of planned supervisions. We saw that some new staff were completing induction handbooks but they were unsure of what was expected of them in that induction. People had not received support from staff who had received appropriate levels of training and support but this was starting to change.

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care. The MCA Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty.

People told us that they were supported to make decisions including accessing the community. A person told us: "They come out with me because they are worried for me…I am building up trust, I am getting better and I am going to talk to staff at my next meeting about going out alone." Staff helped people to understand the decisions they were making, the consequences of those decisions and gained their consent as to how they could be supported.

The majority of people who lived in the home had the ability to make decisions about their life and people told us that staff respected their decisions. A person told us, "They treat me like an adult here not a child, they respect my problems and emotions." Where people did not have the capacity to make decisions applications had been made for an assessment under the Mental Capacity Act 2005. This enabled safeguards to be put in place so that any decision made was in the best interest of people.

We saw that when people communicated non-verbally that they wanted something staff responded quickly so preferred methods of communication were retained.

People we spoke with told us that they enjoyed the food supplied at the home. They told us they had weekly meetings to discuss the meals they wanted to eat and these meals were supplied. There was no evidence that people who had difficulty verbally communicating had been supplied with other ways of choosing the food that they wanted to eat. People were supported to make meals or drinks where they were able to do so. People had access to food and drink when they wanted. We saw that there was sufficient food and drink available and staff told us that stocks of food were replenished several times per week.

The provider had advised us of the steps they were taking to ensure that concerns about the nutritional value of food supplied to a person met the person's needs and wishes. Whilst other people who lived in the home determined what they wanted to eat there was no information available to support people to make healthier choices.

Care plans showed where nutritional advice had been given about food preparation and aids to help people eat independently our observations were that these were followed. This helped to maintain people's skills and reduce the risk of people choking.

People told us that they had been supported to attend health appointments. We looked at some recent letters and diary records of recent health visits and tracked them. We and staff we spoke with were not always able to find a record to show if people had attended these, the outcome

Requires Improvement

Is the service effective?

or if there was any instruction for future care. Prior to our visit we received a complaint that staff did not know what the arrangements had been made for routine health care checks and treatment for a person. These arrangements had not been made. The monitoring of people's on-going health care were not robust enough to ensure changes in health would be found quickly and preventative treatment arranged if needed. People had access to health professionals involved in their care when needed.

Some staff told us that the management of challenging incidents was difficult due to inconsistency in verbal instructions from managers, and that there was little information about how to support people day-to-day. This meant that people were at risk of not receiving care which was consistent and met their needs.

Good

Is the service caring?

Our findings

People told us that they were happy with the support they received from staff. People's comments included: "The staff are nice, really nice" and "I get on fine with staff . . .they like me." We observed that all staff spoke with people in a kind, respectful and caring way. We saw that staff took time to ensure that people who needed supervision received it and responded to each person's method of communication. Throughout the day we saw people who lived in the home responded happily to the staff. People were supported by staff who cared about them.

People we spoke with knew they had care plans; they told us that they were involved in what was in them. One person told us: "Yes they talk to me about my care plans I have meetings with staff about them." A member of staff told us: "I have seen [person's name] being involved in his care planning. There is also time to discuss what's working and what's not working. Staff go out of their way to support the guys [people who lived in the home]" and "Yes I think all the staff here care for people who live in the home." People were able to be involved in their care planning although this was not always recorded well.

People were supported to be as independent as possible. One person told us: "I go out shopping but I don't cook every day. I clean my own bedroom and do my own laundry, except when I'm lazy and staff do it." Another person told us and staff confirmed that they liked "fixing things" in the house and were supported to do this. This helped to ensure that people developed and retained skills towards becoming independent.

People told us they could spend time in their rooms if they wished. People's comments included: "I go to room to play on my [computer game name]" and "I can go to my room and have [items named] when I get angry." There were other areas in the home where people could spend time privately. Where people needed to be supervised at all times staff would supervise in a discreet manner unless they were supporting the person to engage in a task or interest. Therefore people's privacy was respected.

Staff spoke about the people they supported with dignity and respect. However a lack of clean towels on occasions had meant that a person had not been supported with personal care which meant there was a risk that their dignity had not been respected.

Requires Improvement

Is the service responsive?

Our findings

Important people in the lives of people who lived in the home told us that they had raised concerns with the staff and managers of the home and that these concerns had not been resolved. During the inspection we asked to see the home's record of any complaints and dissatisfactions with the quality of the service provided. The registered manager was unable to find any complaint records.

We saw that the provider's audit undertaken in October 2014 stated that there had been no complaints recorded however that an outstanding complaint from a previous audit had yet to be recorded.

Prior to our inspection we referred a complaint that had been made about the service to the provider. The registered manager was aware of these concerns but did not have an adequate record to track these concerns when raised no details of what had been done to resolve the issues when they arose. The person in day to day control of the service had changed several times and this had meant the complainant had not felt listened to. Health professionals told us that they had raised concerns with the management of the home but that this had not resulted in an improvement in the continuity of care for people. They told us that some people who lived in the service were living with autistic spectrum disorders. To lessen the anxieties for people with this condition a week by week planner of activities was used. Health professionals told us that they were being frustrated because these plans had not been in place and had not been followed consistently. For one person this could have led to the increase in the anxieties for one person. This was also found by the provider's audit in October 2014. This had led to increasing dissatisfaction from the people raising concerns.

The lack of detail of these complaints in the complaint record and in some cases repetition of the same concerns showed that complaints were not being managed at the home and actions taken to prevent similar complaints from reoccurring. Complaints and concerns were not being used adequately to plan or sustain any improvement in the home.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

However, the people we spoke with told us that staff were approachable and they could express their thoughts and views about the service. A person told us: "I have a key worker and I feel that I can talk to staff. If I am upset I can speak to [name of member of staff] on the phone if they are not at work and they will sort it."

There were detailed assessments about people's health and social needs. The people who lived in the home we spoke with told us that they had been involved in their plans. They told us that they had regular meetings with staff to discuss them. Where people had the capacity to understand written and pictorial information and easy to read format of their plan of care was available and one person was involved in typing up their plan. This involvement helped people to be involved in setting goals and assess their achievements. Where people were not able to be involved in their care plan there was not enough evidence that the views of other people supporting the person had been taken into account.

People we spoke with told us about interests and past times that they enjoyed and they were happy that they had enough to do. Although one of them told us that they had chosen not to spend money on outside interests they told us how they got involved with the maintenance of the property. People were assisted to be involved in outside interests however the provider's audit in October 2014 indicated that this was not often enough to meet people's goals. A health professional and a visitor were unhappy about the amount of activities that a person had and how these were organised. This lack of organisation could make it difficult for people that had autism spectrum disorders as there was a need to ensure that agreements about time and place for interests were adhered to.

People told us and we saw that people were enabled to maintain contact with their relatives and important people in their lives.

Requires Improvement

Is the service well-led?

Our findings

A person told us: "I see (name of registered manager) on occasion. (Name of recently recruited manager) is nice she listens and talks to you."People, who were able to, discussed their care on a regular basis with staff and managers.

Amongst the comments we received from people involved in people's lives about the management of the home were: "The management changes have been a nightmare….. I have spoken to so many staff. I have emailed the managers and it (the person's care plan) is still not being put into practice," "There have been a lot of changes it is topsy-turvy," and "There is no continuity of staff here; too many changes of managers and too many agency staff."

The registered manager of this home was also responsible for managing another home. Both of these homes were newly registered and required intensive support and leadership to embed good practice. There had been four different staff taking the day-to-day management role in this home since it opened in January 2014. Staff were also providing management support to another of the provider's locations. Staff and relatives of people who used the service told us that this had led to poor communication, low staff morale and, inconsistent treatment and support to people. A member of staff told us, "Its rubbish working here. The managers keep changing. It is disorganised and disorderly." The provider's decision to have a registered manager manage three new services stretched the management team and disrupted the lines of accountability for assessment and monitoring of the home's performance.

There was a lack of due regard to the views of important people in the lives of people who lived in the home who told the management about their concerns and opportunities to take action to improve were lost. People had raised concerns and made complaints and these were not recorded contrary to the information provided in the Provider Information Return (PIR) prior to the inspection. Systems to report safeguarding concerns were confused and information supplied was often inadequate.

Managers did not plan to manage risks sufficiently and did not minimise risks when they were identified quickly enough. For example, the working washing machine had been decommissioned before machine replacement had been delivered and no arrangements had been made to reconnect the decommissioned washing machine. There were no regular visits from a handy man to keep the home in good repair or system for staff to record what maintenance was required. We spoke to a handy man who arrived at our visit and they told us they only visited if something needed doing. The lack of an effective system to ensure equipment was well maintained had led to a person not having personal care delivered as their care plan required and poor infection control processes.

Action had not been taken quickly enough to manage risks to people in the home and to staff. Incidents of behaviour had not been recorded as required by the provider. Appropriate activity planners had not been in place and this could have led to increase in a person's anxieties and incidents. A staff member told us that had been instructed to report and then not to report these incidents to the police. We had not been notified of all incidents that required police to attend the home. This indicated that the level and nature of incidents were not monitored and appropriate strategies adhered to.

The provider had not taken action to address risks which were identified following a staff survey that there was a lack of staff induction and training and supervision these issues remained at this inspection showing that any improvement had not been sustained. Any improvement in planning for this happened since the provider's audit of the home in October 2014 where staff had raised issues of lack of structure and the turnover in staff. The PIR indicated stated there had been significant use of agency staff in the week prior to its submission. Staff were not given the support from management needed for them to feel confident in their role.

The arrangements for the monitoring the quality of the home and the management of risks were not effective and failed to ensure that people were protected from the risk of inappropriate or unsafe care.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control People who lived in the home were not protected against identifiable risks of acquiring an infection due to the lack of systems to prevent infection, and due to the lack of cleanliness and hygiene of premises and equipment for carrying out the regulated activity. Regulation 12(1)(a)(b) and (2)(i)(ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People who lived at the home were not protected because the systems to assess and monitor the quality of the service and identify, assess and manage risks were not sufficiently in place. There was not due regard made to the comments/complaints made by relatives professionals and staff about the quality of the service. There were not sufficient changes made to reflect incidents that had occurred in the home did not continue to be a risk. Reg10 (1)(a)(b) and (2)(b)(i)(iv) and (c)(i)