Precious Homes Limited

Arthur House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**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 for up to six people who live with a learning disability. At the time of the inspection four people were living in the home.

Arthur House also provides a supported living service for up to six people and in addition offers 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 and domiciliary 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. However, 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 our last 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 associated with ligature, self-harm and arson had not been considered. 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.

At this inspection in January 2020 we identified that known risks to two people's safety had not been adequately assessed and mitigated against. The assessments in place continued to lack robust detail about the risks posed to people and how these should be managed. Practice at the service continued to place people at risk of harm and did not protect them from actual harm. At the time of the inspection we observed enough staff on duty to support people, when necessary. The provider had a safeguarding process in place and had made improvements to ensure safeguarding alerts where escalated to the appropriate authority when necessary. The management of medicines had improved, and further improvements were planned. There had been one serious incident in January 2020, however the provider had learnt from the incident and had put measures into place to reduce the risk of re-occurrence.

The provider had not ensured that their systems and processes were effective in enabling staff to provide safe and good quality care for people. Professionals told us their recommendations to improve people's

health and well-being were not consistently followed. The management arrangements currently in place had demonstrated some improvements and this was reflected by people and staff in their comments. Systems in respect of the monitoring of the service remained in development. The provider sent us additional information following our inspection to demonstrate plans for future monitoring and audit systems.

Members of the management team had not effectively identified and managed risks and incidents, therefore, people had experienced harm and were placed at on-going risk of harm.

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 focused inspection was prompted in part due to concerns received about people's safety. A decision was made for us to inspect and examine those risks. In addition, we received a notification of a specific incident. Following which a person using the service self-harmed. The inspection examined the circumstances of the incident. We undertook a focused inspection to review the Key Questions of Safe and Well-led only.
We reviewed the information we held about the service. No new areas of concern were identified in the other Key Questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection.

The overall rating for the service has remained inadequate. This is based on the findings at this inspection.

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 continued breaches in relation to keeping people safe, 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 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.

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 provider is legally responsible for how the service is run and for the quality and safety of the care provided. At the time of the inspection the service did not have a manager registered with the Care Quality Commission. One of the provider's operations managers was covering the service in their absence.

Notice of inspection
This inspection was unannounced.

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. In addition, we spoke with two health professionals prior to our inspection. We used all of this information to plan our inspection.

During the inspection
We briefly met three people who lived at Arthur House. We spoke with three members of staff including the operations manager, deputy manager and one support worker from the residential service.

We reviewed a range of records across the service. This included two people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
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 Inadequate. At this inspection this key question remains the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

●At our last inspection in October 2019, 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.

● At this inspection in January 2020 we identified that known risks to two people's safety had not been adequately assessed and mitigated against. The assessments were improved but remained ineffective as staff had not understood the risk.

● Practice at the service placed people at risk of harm and did not protect them from actual harm. For example, one person's risk assessment outlined specific checks should be completed to ensure specific objects were removed to prevent self-harm. We were advised and saw that these checks had been completed and recorded however they were ineffective. Checks failed to identify these items were present and staff failed to remove them from the environment. As a result, the person caused serious avoidable harm to themselves.

● At our last inspection we found the provider had failed to ensure risks relating to people committing arson. At this inspection insufficient improvement had been made. Staff did not have shared understanding of people's risks and how to support people safely in respect of arson. Assessments and guidance for staff about people's risks were incomplete and did not ensure people could always be kept safe. As a result, people were exposed to the on-going risk of potential harm.

● We received concerns from health professionals prior to this inspection that food items that could cause specific people harm if consumed were left unattended in communal areas. The health professional advised that the person had consumed some of the food and the area manager corroborated this and told us staff had left food unattended in a communal area. Staff we spoke with during our inspection were aware of this risk, however, on this occasion had not followed the person's risk assessment.

●We received concerns from health professionals prior to this inspection in respect of one person being put at risk by a failure to effectively identify and manage a deterioration in their mental health. Whilst this information had been brought to the attention of the registered manager the actions required by staff to protect them from harm had not been considered and outlined in their care plan or risk assessment. Staff did not have shared understanding of the person's risks. This placed the person at on-going risk of potential harm as staff would not be aware of the person's current care needs.

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

● Following our inspection, the provider sent us evidence to demonstrate how risks to people had been mitigated in relation to self-harm, nutritional risks and arson. The area operations manager overseeing the service had understood the risks arising from the incidents outlined above and had shared learning with staff. Staff were able to describe what action was being taken to prevent future incidents arising. We will continue to monitor the service to ensure the actions described by staff have been taken, improvements have been sustained and we will review this at our next inspection.
● During our last inspection we saw garden tools were left unsecured in the garden area. At this inspection, we saw this had been addressed and the risks had been mitigated.
● During our last inspection we saw unsecured hazardous substances on the premises. We found these substances were accessible for all people who lived at Arthur House. At this inspection, we saw this had been addressed and the risks had been mitigated.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● During the last inspection staff did not always recognise incidents of a safeguarding nature and not all safeguarding allegations had been escalated to the appropriate authorities. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Safeguarding service users from abuse and improper treatment.
●At this focused inspection we found improvements had been made and the service are no longer in breach of this regulation. Staff we spoke understood their responsibilities to report all concerns. A member of staff told us, "I would report any concerns to the manager or CQC." We saw that identified potential safeguarding allegations had been escalated to the appropriate authorities.
●During the last inspection, processes to learn lessons when incidents or mistakes happened were not embedded within the culture of the staff team. At this focused inspection, despite a serious incident occurring in January 2020, the service had recognised risks following incidents and had then mitigated against the likelihood of further incidents.

Using medicines safely
● At our last inspection people did not always receive their medicines as prescribed. Medicines were not always received, stored, administered and disposed of safely. At this inspection the area operations manager had made some improvements and implemented changes to ensure staff administered medicines to people safely.

Staffing and recruitment
● We reviewed the provider's staffing levels during our last comprehensive inspection and did not identify any concerns. We had received additional information prior to this inspection to suggest that there had been staff shortages in the service. The area operations manager confirmed issues had arisen but these at been addressed. At the time of the inspection, there were no current vacancies within the service and we observed sufficient numbers of staff on duty supporting people.
● We reviewed the provider's recruitment process during our last comprehensive inspection. We found there were systems in place for the safe recruitment of staff. We had received no additional information to suggest that this situation had changed. We did not look at specific staff files during this focussed inspection.

Preventing and controlling infection
● We reviewed the provider's controlling infection processes during our last comprehensive inspection. We found there were systems in place to manage the control and prevention of infection. We had received no additional information to suggest that this situation had changed and identified no concerns during this focussed inspection.

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 Inadequate. At this inspection this key question has remained the same. This meant there were 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

● At the last inspection, there were inadequate systems in place to monitor the quality and safety of service provided. 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 significant 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. The provider was unaware of the significant ligature risks, self-harm and arson risks to some people living at the home.

● At this inspection we found the area operations manager had begun to take steps to make improvements to the management of risk and governance in the service. However, the improvements made had not yet been fully embedded and further improvement was still needed. An improvement plan was being developed but was not yet effective at the time of the inspection and significant risk remained.

● Prior to this inspection we received continued information of potential concern. We wrote to the registered provider to outline these concerns and received assurances that appropriate action had been taken to protect people from harm. When we returned for this inspection, we found the action described had been insufficient and actual harm had occurred. People had been exposed to actual harm and the ongoing risk of significant harm. Further action was subsequently taken to make improvements and the level of risk to people had since reduced.

● The provider had failed to identify that systems to ensure risk assessment processes were effective continued to be inadequate. They had failed to identify that risks to people were fully considered or that actions outlined in improved risk assessments were effectively completed by staff. As a result, people had been exposed to harm.

●The systems in place to ensure the management team were made aware of significant incidents that had occurred and significant risks to people required further improvement. During the inspection we confirmed with staff that one person had admitted deliberate self-harm. This had not been shared with the management team and as a result the risk was not managed. This meant the person was exposed to the risk of 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.

●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 was in place.

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

●Following our inspection, the provider sent us evidence to demonstrate how risks to people had been mitigated in relation to self-harm, nutritional risks and arson. The area operations manager overseeing the service had understood the risks and shared these with staff. We will continue to monitor the service to ensure the improvements have been implemented and sustained. We will review this at our next inspection.
● At the last inspection the provider had not ensured that governance systems around the administration of medicines were effective and robust. At this inspection the area operations manager had made some improvements.
●At the last inspection 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. At this inspection, potential safeguarding concerns had been escalated to the relevant people.
● At this focused inspection, systems in respect of the monitoring of the service remained in development. The area operations manager sent us additional information following our inspection to demonstrate plans for future monitoring and audit systems.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● At the last inspection, the provider had not ensured a positive culture within the service that achieved good outcomes for people. At this inspection there had been some improvements and further were required.
● For example, the provider had purchased some additional equipment to support one person with sensory stimulation.
● Relatives and health professionals continued to tell us after the last inspection that the service was not consistently responsive to people's needs. These concerns had been investigated by the area operations manager who confirmed that there had been several process failures. Immediate actions had been taken to resolve the concerns.

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
● At the last inspection we identified that 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. 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.
●At this focused inspection we saw some improvements had been made and the service are no longer in breach of this regulation. When things had gone wrong, these had been escalated to the appropriate people and shared with staff to prevent re-occurrence.
●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
● At our last inspection the provider had not acted on feedback given to learn and improve the quality of

care provided.
● At this inspection we saw evidence that the provider had made some improvements to use feedback to make improvements to the service. For example, a new system for the monitoring of continence equipment had been implemented to prevent people from running low of supplies. This would help to mitigate risks associated with skin integrity.
●People had been involved in regular meetings with staff in which they could discuss the service and what activities they would like. We observed staff engaging with people in a positive way.
● We observed people were comfortable in the presence of the area operations manager. Staff we spoke with spoke positively about the present management arrangements.
● The area operations manager had continued to send regular action plans and updates to demonstrate their improvements and future.

Working in partnership with others
● The quality assurance systems were limited in their effectiveness to ensure continuous improvement. We identified failings in several areas which should have been addressed through the operation of robust systems of governance, audit and monitoring.
● We saw some evidence that the service did work in partnership with other professionals and agencies to help meet people's needs. However, health professionals continued to tell us their recommendations to enhance people's health and well-being were not consistently 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 17 HSCA RA Regulations 2014 Good governance The provider did not have robust, consistent and adequate systems in place to monitor the quality of the service. The provider did not have consistent effective systems in place to assess and monitor risks relating to the health, safety and welfare of people using the service. Regulation 17 (1) (2)(a)(b)

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. Regulation 12 (2) (a) (h)

The enforcement action we took:

Urgent conditions imposed on the provider's registration will remain in place.