Choices Housing Association Limited

Choices Housing Association Limited - 17 Norton Avenue

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service on 27 January 2017. This was an unannounced inspection. At our previous inspection in August 2014, we found that the provider was meeting the required standards we inspected them against and the service was rated as 'Good'.

The service is registered to provide accommodation and personal care for up to six people. People who use the service have learning and physical disabilities. At the time of our inspection six people were using the service.

The service had a registered manager. However, staff told us they had left the service in September 2016. 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 and associated Regulations about how the service is run. The newly appointed home manager told us they were applying to register with us.

At this inspection, we identified two Regulatory Breaches. You can see what action we told the provider to take at the back of the full version of the report.

The provider had not told us about the management changes at the home as required by law.

Risks to people's health, safety and wellbeing were not always assessed and planned for to ensure people received care that was consistently safe.

People didn't always receive their prescribed medicines as they were not always available to be administered.

People's health needs were not always effectively monitored as planned, and advice from healthcare professionals was not always followed to promote people's health, safety and wellbeing.

The information in people's care records was not always accurate or up to date to protect them from the risks of receiving unsuitable and inconsistent care.

People's dignity was not consistently promoted and, people were not always enabled to be involved in making choices about their everyday care. This was because appropriate communication tools were not always available.

People were supported to eat and drink, but this support was not always provided in a safe manner to protect people from the risk of choking.

The new management team had started to assess the quality of care. As a result of this areas for

improvement had been identified and plans were being formulated to improve people's care experiences. Staff spoke positively about changes the management team had introduced and they told us they had confidence in the new management team.

There were enough staff available to provide people with prompt care and staff were recruited in a manner that protected people from abuse.

Staff knew how to identify and report potential abuse and they received training to enable them to carry out their role of delivering care.

The requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were followed. This ensured that decisions were made in people's best interests when they were unable to make these decisions for themselves.

People were supported to be independent and people's right to privacy was respected.

There was a formal complaints procedure in place that was followed when formal complaints were received.

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

The service was not consistently safe. Risks to people's health, safety and wellbeing were not always assessed, planned for or managed in a manner that promoted safety. Effective systems were not in place to ensure that people's prescribed medicines were consistently available.

Safe staffing levels were maintained and staff were recruited in a safe manner that protected people from the risk of avoidable harm.

Staff knew how to identify and report potential abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective. People's health and dietary needs were not always effectively monitored and managed to promote their health and wellbeing.

People could access health care professionals when needed. However, their advice was not always incorporated into people's care plans or followed to promote their health, safety and wellbeing.

Staff supported people to make decisions about their care in accordance with current legislation.

Staff received training to provide them with the knowledge and skills needed to meet people's needs.

Is the service caring?

Requires Improvement

The service was not consistently caring. People's dignity was not always promoted and people were not always supported to be involved in making choices about their everyday care.

Permanent staff knew people's likes and interests and used this information to interact with people in a positive caring manner.

People's right to privacy was promoted and respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. People's care records were not always accurate and up to date. This meant that people were at risk of receiving unsuitable and inconsistent care.

Effective systems were not in place to ensure all people were as involved in the planning and review of their care as they could be.

People were supported to participate in leisure and social based activities inside and outside of the home.

A complaints procedure was in place and formal complaints were managed in line with this procedure.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. There had been a number of recent management changes which had caused some unrest at the home.

The management team had identified some areas for improvement and had planned or were planning to address these. We were unable to identify if these plans were effective as they had not all been implemented at the time of our inspection.

Staff had confidence in the new management team and spoke positively about the changes that were being made to improve people's care.

Choices Housing Association Limited - 17 Norton Avenue

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 was 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.

We undertook an unannounced inspection of Choices Housing Association Limited - 17 Norton Avenue on 27 January 2017. We inspected the service against the five questions we ask about services: is the service safe, effective, caring, responsive and well-led? Our inspection team consisted of one inspector.

We checked the information we held about the service and provider. This included the statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law. 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. We used this information to formulate our inspection plan.

We spoke with five people who used the service. However, due to people's communication difficulties four of these five people were not able to verbally tell us about their care experiences. We spoke with three staff members, the deputy manager and the home manager. We also reviewed feedback from people's relatives via the provider's most recent satisfaction survey. We did this to gain people's views about the care and to check that standards of care were being met.

We observed how the staff interacted with people in communal areas and we looked at the care records of

two people who used the service, to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included staff files, rotas and quality assurance records.

Following our inspection, we shared our findings with the local authority. We did this to ensure people who had been exposed to harm were safeguarded.

Requires Improvement

Is the service safe?

Our findings

We found that some risks to people's health, safety and wellbeing had been assessed and planned for. However, improvements were needed to ensure that all significant risks posed to people had been assessed and planned for, to ensure people received safe and consistent care. For example, one person was supported to regularly access the community to participate in an activity that was important to them. Significant risks were posed to this person and other people during this activity. These risks had not been formally assessed and planned for and no guidance was available in this person's records for the staff to refer to. This had resulted in staff using different approaches when they supported this person to access transport and services in the community. This meant that this person's risks had not been managed in an inconsistent manner, placing them and others at risk of harm.

We found that the information in people's care records about their risks and how these should be managed was not always accurate and up to date. For example, one person's care records contained information from a healthcare professional stating the diet the person needed to minimise their risk of choking. This advice had been given in October 2016 and had not yet been incorporated into the person's care records or the prompt sheet that the staff referred to when preparing this person's meals. We were later showed a newly written care plan that detailed the person's current dietary needs. However, this information was stored in a staff communication folder and had not yet been read and understood by all the staff. We saw the person was served an unsuitable diet at lunchtime on the day of our inspection. This was because at that time, the staff were unaware that the person should not eat the food they were served because of the choking risk that it posed to them. Staff changed the person's lunch meal when they observed them coughing whilst eating it. We raised this with the home manager, who immediately updated this person's dietary prompt sheet and also updated the staff. This meant this person was placed at risk of harm as staff did not have access to the information they needed to promote this person's safety.

We found that medicines were stored safely. However, effective systems were not in place to ensure people received their prescribed medicines when they needed them. One person's medicine administration records (MAR) showed that they had not had one of their prescribed creams administered for a seven day period. This was because this medicine had not been in stock at the home during that time. Staff told us there had been a delay in the delivery of this medicine. However, the medicine had not been ordered in suitable time to ensure stock was consistently available. Staff told us this cream was applied to manage the person's sore and red skin. The person's care records showed their skin had been red and sore on at least three of the days when the cream was unavailable. This meant the person had not had the prescribed treatment for their skin condition when they needed it.

The above evidence demonstrates that effective systems were not in place to ensure people received their care in a consistently safe manner. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People confirmed that they were supported from staff when they needed support. One person said, "They always help me". We saw that this was the case as people received prompt support from the staff to ensure

their care needs were met. For example, one person shouted at times to express their need for assistance or reassurance. We saw that when this person was seated in a room away from the staff, staff responded promptly in response to their shouting. Staff told us there were enough staff to ensure people's personal and social care needs were met. One staff member said, "Yes, we definitely have enough staff. Things run nice and smoothly and we can do things on the spur of the moment". The home manager told us that staffing levels were regularly reviewed to ensure they met people's needs, and we saw that staffing levels were increased when needed. For example, staff rotas showed that staffing numbers increased to enable people to access and participate in community activities.

People confirmed that they felt safe and we found that they were protected from the risk of abuse. Staff explained how they would recognise and report abuse. One staff member said, "I'm not afraid to report abuse. I need to speak for these people as they can't all speak for themselves". Procedures were in place that ensured concerns about people's safety were appropriately reported to the management team and the local authority's safeguarding team. We saw that these procedures were followed when required.

People were comfortable around the staff which showed they felt safe in their company. Staff told us and we saw that recruitment checks were in place to ensure staff were suitable to work at the service. These checks included requesting and checking references of the staffs' characters and their suitability to work with the people who used the service.

Requires Improvement

Is the service effective?

Our findings

Care records showed that some people's health needs were being effectively monitored. However, improvements were needed to ensure effective health monitoring was consistently completed. For example, one person's care records showed a plan was in place to support them to lose weight to promote their health and wellbeing. This plan stated the person needed to be weighed on a monthly basis. However, their care records showed they had not been weighed for approximately four months. Staff told us this was because the person struggled to use the home's weighing scales. Prompt action had been taken to ensure this person's weight was monitored via an alternative method. We spoke with the home manager about this. They said they had identified this issue and were working on an alternative approach to enable this person's weight to be monitored as planned.

People confirmed and care records showed advice from health care professionals was sought when needed. This included emergency medical intervention. However, improvements were needed to ensure that advice given by health professionals was incorporated into people's care plans and acted upon. For example, one person's care plan showed that medical advice should be sought if a person's fluid intake fell below their recommended target. This advice had not been incorporated into the person's eating and drinking care plan and we saw that action had not been taken when their fluid intake fell below their recommended target. This showed that advice from health care professionals was not always followed to promote people's health and wellbeing.

Care records showed that people were supported to eat a healthy, varied diet. For example, we saw a healthy approach to eating had enabled one person to lose weight in accordance with their healthy eating care plan. However, improvements were needed to ensure professional advice in relation to people's eating needs was followed to ensure the food they ate was safe.

We found that the requirements of the Mental Capacity Act 2005 (MCA) were followed. The 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff demonstrated they understood the principles of the MCA. Care records showed that people who lacked the capacity to make certain decisions about their care were supported to do so by the staff, health and social care professionals, family members and advocates (advocates help people to express their opinions and views when people struggle or are unable to do this for themselves). We saw that when needed, decisions were made in people's best interests in accordance with the MCA. For example, a decision had been made in one person's best interests for their relative to have overall management of their finances as they were unable to make complex financial decisions. Staff supported this person to make choices about how they spent small amounts of their money to promote their independence and decision making in a safe and planned manner.

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 Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). All people using the service were restricted at times to promote their safety. Care records showed that a DoLS application had been made for each person in response to their individual restrictions. This meant that when people needed to be restricted to keep them safe, these restrictions were lawful. Appropriate staffing levels ensured that people who needed support to access the community were not prevented from doing so.

Staff told us and records showed that they received training to provide them with the knowledge and skills required to meet people's needs. One staff member said, "The first aid training was amazing, I learned things I never knew". This staff member told us they had not needed to use this training at work, but they felt able and confident to do so when needed. Another staff member told us how the training they had received had enabled them to move people and objects safely at the home. They said, "The safer handling training has helped me to use the hoists safely and move the big chairs around the home without hurting me or the service users".

Requires Improvement

Is the service caring?

Our findings

Staff told us how they would promote people's dignity. One staff member said, "I treat people the way I would want to be treated". However, we found that people's dignity was not consistently promoted. For example, one person who used the service was not supported to wash spilled food off their face at lunch time. This person's face remained stained with food all afternoon and at dinner despite staff engaging with this person to provide other care support, such as accessing drinks. We told the home manager about this and they acknowledged and confirmed that staff had not ensured this person's dignity needs had been met. We also heard one staff member say to another staff member, "I've put [person who used the service] on the toilet" in front of other people who were using the service.

Systems were not in place to enable people to be consistently involved in making choices about their care. For example, a visiting health care professional had recommended pictorial cards were used to enable the person to make choices about foods and activities. Staff told us and the home manager confirmed that these cards were not available at the home. This meant that the advice from this health care professional was not used to support this person to make and communicate their everyday care choices to the best of their ability. Staff told us a meeting was held with people every week to plan meals and activities. We asked staff how they ensured all people were involved in these meetings. One staff member said, "It's difficult as they can't all talk, but we know their likes and dislikes". The home manager told us they planned to introduce more pictorial communication tools at the home to enable people to be more involved in making choices about their everyday care.

People told us their independence was promoted. One person said, "I've tidied my room this morning with [staff member]". We saw this person was supported to move to the kitchen, so they could be involved in the preparation of the evening meal. The person responded positively to this and they showed they enjoyed the interaction with the staff during this time as they were smiling and chatting to the staff.

We observed some positive and caring interactions between staff and people that showed staff understood people's likes and interests. For example, we heard one staff member singing to a person who used the service. This made the person smile. The song they sung to them was from a film that the person confirmed they enjoyed which showed the staff knew their likes and interests. This staff member also showed that they respected and valued all the people who used the service when they said, "I love each and every person here for different reasons. They all have amazing personalities".

We saw that people's bedrooms were decorated in a manner that reflected their interests and needs. For example, one person who enjoyed music had framed records on their walls. People could access their bedrooms when they wished to do so. This meant that people's right to privacy was respected.

Feedback from the relatives from the provider's last satisfaction survey showed they were happy with the care that their relations received.

Requires Improvement

Is the service responsive?

Our findings

We saw that permanent staff knew and met people's care needs and preferences. For example, we saw one person was wearing a medical device to help maintain and promote safe and comfortable positioning of their neck. Staff told us that a health professional had prescribed this device and the staff showed that they knew how to apply it. However, we found that people's care plans did not always contain accurate and up to date information relating to their care needs and preferences. For example, the care plan of the person who needed to wear the medical device did not state that this is what they required. Their care plan referred to a different medical device that was used to manage their risk of head injuries. Staff told us this device was no longer needed or used, but their care plan had not been updated to reflect this. This meant that new or temporary staff would not have access to up to date and accurate information from this person's care plan. We saw that the manufacturer's guidance for the application of this medical device was contained in a separate care folder, for staff to view if they knew it was there. However, this had not been included in the person's care plan. This placed the person at risk of receiving unsafe and inconsistent care that was not responsive to their needs. This risk was increased as the staff and the home manager confirmed that temporary staff were being used at the service. The home manager told us they were aware of this concern and were planning to review and update all the care records at the service.

This was an additional breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The home manager told us they were aware of this concern and were planning to review and update all the care records at the service.

Feedback from relatives from the provider's most recent satisfaction survey showed that relatives felt they were involved in their relations care. However, improvements were also needed to ensure that people could consistently be involved in the review of their care needs and care preferences. Care records showed that reviews did take place, but the communication methods needed to involve people in this process were not in place. For example, pictorial information was not readily available and reviews were all in a written format that some people were unable to understand as they could not read. This meant people were not supported to be involved to their maximum potential and we couldn't be assured that care was being delivered in accordance with people's care preferences.

Some people who used the service were unable to understand and follow the formal complaints procedure. Weekly meetings were held at the service where staff verbally asked people if they were happy with the food, activities and their care. Again, some people's communication difficulties meant they may not have understood the information presented in this verbal format at these meetings. The home manager confirmed that people who used the service needed more pictorial information to enable them to be more involved in their care and they planned to address this. We will check that these improvements have been made at our next inspection.

People told us and we saw that they were encouraged to participate in leisure and social based activities that met their individual preferences. For example, one person told us they were supported to access the community to go shopping as they enjoyed this activity. They also said, "I like going to social club". This

person's care records showed they were supported to attend this club when they wanted to do so. We saw staff supported people to participate in a number of leisure based activities during our inspection. This included listening to music, drawing, foot massage, watching videos and accessing the community.

People told us and we saw that their families and friends could visit them at any time. One person confirmed that staff had supported them to invite their boyfriend to visit them. During our inspection, a friend of a number of people at the home visited and staff welcomed this person and offered them a drink and snack. This showed that staff supported people to maintain relationships that were important to them.

Complaints records showed that no formal complaints had been made about people's care. However, we saw that complaints relating to other areas of the management of the service had been addressed in accordance with the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

On arrival at the service, staff told us the registered manager had not been working at the location since September 2016. The provider had not informed us of this change which is reportable to us by law. This was a breach of Regulation 15 of the Care Quality Commission (Registration) Regulations 2009.

Although we found there were concerns with the safety, effectiveness and responsiveness of the service, the home manager and deputy manager showed that they had identified most of the areas of concern and were taking action to address these. For example, the home manager and deputy manager told us that they had recently identified some concerns with how medicines were managed at the home. They told us they had made some changes to the way that medicines were managed to improve safety. For example, improvements had been made to the storage and administration of medicines. Staff confirmed these changes had been effective. One staff member said, "There's been loads of changes. The way we do the medicines has changed for the better and it makes more sense". The deputy manager told us recent checks had showed the new medicines systems were working, but they also told us that further changes were required to ensure people's medicines were consistently available. They said, "We had no warning that [person who used the service's] cream was running out. Creams are kept in people's bedrooms, but we are going to move them into the office cupboard with the other medicines so we can monitor them better". This showed they had identified that improvements were required and plans were being put in place to address safety concerns. We will check that this change has been effective at our next inspection.

The management team were also aware of some of the gaps that we found in people's risk assessments and care plans. The home manager said, "We are aware there are a lot missing from them (care records). We've got a new format for our care plans and we are starting to use them now". We saw that new care plans were being introduced. For example, we saw that a new care plan had been written to reflect a person's changed dietary needs as the information in this person's care records that were in use was not accurate or up to date. However an effective system was not in place to ensure staff read and understood the new care plans that had been devised. For example, the home confirmed that the staff member who supported the person to eat an unsafe meal on the day of our inspection had not yet read the person's new care plan, which meant they were not aware of their current dietary needs. Again, the home manager told us they were aware of this issue and they were planning to address this by making sure staff read a set number of new care plans before they started each shift. We will check that this change has been effective at our next inspection.

Staff told us that they had not had regular meetings with the management team to assess and review their development needs for a significant time period. However, the home manager had devised a supervision and appraisal schedule that was due to be imminently implemented at the home. This showed the home manager had planned to assess and monitor the staffs' development needs. We will check that this has been effectively implemented at our next inspection.

Staff told us that the recent management changes had caused some unrest at the home for themselves and the people who used the service. However, all the staff we spoke with talked positively about the new management team and the changes they were making to improve care. One staff member said, "It was a bit

of an upheaval when [the registered manager] left, but things are starting to run smoothly now. Things are being done now that weren't being done before. I think we had all got a bit too comfortable before, but I'm happy with the changes the new manager is making". Another staff member said, "[The registered manager] left, then a temporary manager came, then the new home manager started. All the change isn't ideal and it's hard to plan ahead, but I think things will be good now". This showed that the staff had confidence in the new management team.

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 15 Registration Regulations 2009 Notifications – notices of change On arrival at the service, staff told us the registered manager had not been working at the location since September 2016. The provider had not informed us of this change which is reportable to us by law.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Effective systems were not in place to ensure people received their care in a consistently safe manner.