

# Chosen Care Limited

# Chosen Court

## Inspection report

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### Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

**Requires Improvement** ●

Is the service well-led?

**Inadequate** ●

# Summary of findings

## Overall summary

### About the service

Chosen Court is a supported living service to people with a learning disability. A supported living service is where people live in their own home and receive care and support in order to promote their independence. The service was supporting 17 people at the time of our inspection.

### People's experience of using this service and what we found

The provider's quality assurance systems to assess, monitor and improve the quality and safety of the service were not operated effectively. Shortfalls in the service had therefore not always been promptly identified and addressed.

At the time of the inspection the local authority was working closely with the provider to make the required improvements. The provider kept us updated of the action they were taking to address the risk and quality concerns.

The service did not always consistently apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons:

People were supported by staff who had been recruited safely. However, not all practices were safe enough.

Risks associated with people's care needs were not always appropriately assessed and information for staff on how to provide safe support to people were not always documented.

People were not always adequately supported to keep their homes well maintained and cleaned.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

### Rating at last inspection

The last rating for this service was good (published 13 December 2018).

### Why we inspected

The inspection was prompted in part due to concerns received about the management of people's medicines, the environment and people's safety. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the Key Questions of safe and well-led only.

### Enforcement

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report. The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have identified breaches in relation to safe care and treatment as well as the governance of the service at this inspection.

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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Chosen Court on our website at [www.cqc.org.uk](http://www.cqc.org.uk)

#### Follow up

The provider started taking immediate action during our inspection to address the shortfalls we found and to mitigate the risks.

We will request to 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 and we will request an updated action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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 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 always 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.

# Chosen Court

## 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 one adult social care inspector.

#### Service and service type

This service provides care and support to people living in a number of '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.

The service did not have a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

#### Notice of inspection

We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection. Some of the people using the service could not always consent to a home visit from an inspector. This meant that we had to arrange for a 'best interests' decision about this.

#### What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information

helps support our inspections. We used all of this information to plan our inspection.

#### During the inspection

We visited three supported living households over three separate days and spent time in the office and in people's homes. We spoke with two people who used the service and no relatives about their experience of the care provided. We requested the contact details for relatives on a number of occasions from the acting manager and provider but had no response. We spoke with five members of staff including the provider, acting manager and three care staff.

We reviewed a range of records. This included six 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 found. We spoke with two health professionals who regularly visit the service.

# Is the service safe?

## Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People were at risk of receiving inconsistent or unsafe care; care plans and risk assessments did not have enough information about people's needs or to guide staff on how to safely support them. When safety incidents had occurred people's risks had not been reviewed to ensure staff would continue to provide safe care. For example, staff had recorded six falls for one person from May to November 2019, some injuries required medical attention. However, their falls had not been scrutinised to determine whether staff had responded appropriately or to recognise and respond to patterns and triggers to minimise the risk of falls occurring again. Their mobility and transfer risk assessment had also not been reviewed following their falls to ensure it was effective and there was minimal guidance available for staff to know how to support them to transfer safely and remain independent.
- Another person had suffered high levels of anxiety during 2019 and was regularly placing themselves at risk of self-harm. There was little guidance in place for this person and assessments had not been updated since a serious incident that occurred in August 2019. This meant that staff supporting them would not know critical information about them and how to support them at times of distress.
- We are uncertain whether people were always been supported to keep their homes safe. The housing association had completed a fire risk assessment at one household in May 2019 that identified improvements were needed; this assessment had been rated 'unsatisfactory'. We saw fire doors were in place, but they did not all have fire door release mechanisms and one fire extinguisher was missing from the kitchen area. We requested a copy of the fire risk assessment on at least three occasions during and after our inspection but did not receive a copy. We are therefore unable to ascertain whether actions had been fully completed.

Using medicines safely

- Medicine administration records (MAR) were used to record when people received their prescribed medicines. These records helped to reduce the occurrence of medicine errors as they recorded the time and dose of the medicine given. However, in one household records were unclear and it was hard to determine who was having one medicine as the medicine was not labelled and were not noted on the medicine administration records (MAR). This increased the risk of people receiving the wrong medicines.
- Guidance was not always in place for staff to know how people liked to take their medicines.
- Where people were prescribed medicines on an 'as required' basis, there was not always guidance for staff to know when and why to use them.

Preventing and controlling infection

- At one household we visited safe infection control procedures were not in place to minimise the risk of

cross contamination in regard to one person's personal care needs. This person's needs had changed in November 2019 and medical advice had been sought. However, their care records had not been updated and procedures had not been put in place to support this person whilst requiring extra support with their personal care to manage the risk of infection. One visiting health professional told us they had not been made aware of the complexity of this situation and was not shown relevant records when they recently visited. This meant that the person was not getting all the relevant support from health professionals as they did not have all the information they needed to support the person effectively.

- The service had not taken prompt action to support people to maintain their homes and keep them clean. There were several malodours throughout people's home during our visits. Staff told us, "It's really not nice to work in, let alone live in. The carpets all smell and require new furnishings." The provider told us a maintenance schedule was in place to rectify these issues and they were liaising with housing providers.

People were at risk of harm as safe and effective systems were not continually being used to identify, manage and monitor people's risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- A new and improved system and procedure for medicine management had been implemented at one household we visited which was safe and effective; however this had not been completed at the other households we visited. The acting manager and provider told us, "We plan to implement these new safer procedures at all services and we are in the process of this."

- We received an improvement plan from the provider during our inspection showing the action they will be taking to address the shortfalls we found.

Systems and processes to safeguard people from the risk of abuse.

- When we spoke to staff, they were able to tell us what to do if people were at risk of abuse, however 15 out of 22 staff members safeguarding training had expired.

Staffing and recruitment

- The manager routinely reviewed the staffing numbers with the provider. Each person was allocated individual support hours as per their contract.

- New staff had been recruited using safer recruitment procedures.



# Is the service well-led?

## Our findings

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

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider was slow in developing sufficient oversight of the service to ensure people received the care and support they needed that promoted their wellbeing and protected them from harm. For example, quality assurance systems were not undertaken robustly or always completed. Staff practice in relation to people's medicine management, health and safety, care and support planning, accidents and incidents, risk assessment and staff training were not routinely monitored.
- The provider and management team had not recognised that some of the needs of people were not being met and had not been effective in checking compliance with action plans and regulations. Had the provider implemented effective monitoring systems they would have identified the concerns we found in relation to accidents, incidents, fire safety, risk assessments and medicines. We identified these risk areas on the inspection which may have been missed as they had not been identified and acted upon prior to our inspection.
- People were being cared for by staff who knew them and were doing their best to provide person centred care however; people were not having fulfilled lives and it was unclear if people were achieving good outcomes as records were not always in place to describe the support people needed and had received.
- Since our last inspection, the ratings for the Safe and Well-led key questions had deteriorated.

Not establishing and operating effective systems to assess, monitor and improve the quality and safety of the services provided was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider took immediate action to address the shortfalls we found. The provider had a new Area Operations Manager who visited the service regularly to check ongoing compliance with the Health and Social Care Act 2008 and that improvements were being made.

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

- The manager and provider recognised that mistakes had been made. They were listening to people, respected their views, and apologised when they had experienced care which they believed was not appropriate or had not met their needs.
- The manager was aware of their responsibility to inform the Commission of significant events in line with statutory duties.

- The management team spoke openly and honestly throughout the inspection process.

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

- The manager had identified that staff were not receiving regular supervisions, appraisals and irregular team meetings, as a result staff had received supervision inconsistently. This meant staff morale was low and some staff felt undervalued. The manager was working hard to improve the culture of the service but recognised this would take time to be embedded. One staff member said, "The manager is so busy, there is no time. We feel like we do not want to ask questions; so we just deal with things ourselves. Things have improved the last few weeks."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There were no records of discussions with people or resident meetings to show us people had an input into their care and/or lives. ●

Continuous learning and improving care

- The provider and acting manager told us they knew areas where the service required improvement and had implemented a robust action plan and were working towards improving these areas. Each person was due to have a full review of their care and support needs and all records were due to be updated by January 2020.
- The provider and acting manager had implemented new systems and processes to ensure the service was being closely monitored and told us, "We know things need to improve, we are focussing on safety first, then staff morale and the environment. We have started our maintenance schedule and staff team meetings have been introduced."

Working in partnership with others

- The service had worked collaboratively with the local authority throughout the inspection. Regular multi-agency meetings had been held with them and CQC and representations of the provider had attended and given updates on improvements to the service.