Choice Support

Choice Support - 18 Varty Road

Inspection report

18 Vartry Road
London N15
Tel: 0208 802 8700
Website: www.choicesupport.org.uk

Date of inspection visit: 29 May 2015
Date of publication: 24/08/2015

Ratings

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

Overall summary

This inspection took place on 29 May 2015 and was unannounced. The previous inspection was on 29 November 2013 where the service was found to be meeting the standards we inspected at that time. This care home provides accommodation and care to four people who have a learning disability, some of whom also have an autistic spectrum condition. At the time of this inspection there were four people living in the home in single bedrooms. People shared a lounge and two bathrooms.

The service has a registered manager. 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.

We found people were cared for by suitably trained and experienced staff who knew their needs well. Staff

Summary of findings

supported people to follow their own chosen individual routines and to take part in activities they liked, such as shopping, visiting local parks, eating out and going on holiday.

People's care plans contained a good level of information setting out how each person should be supported. Permanent staff had good relationships with the people living at the home but at the time of this inspection there were not enough permanent staff.

People were settled in the home and their representatives (family member or professional working with them) said they were happy and received good care.

People's privacy at night was not protected as there were not suitable arrangements in place to ensure people could not go into other people's bedrooms without their consent.

Financial practices were not robust enough to ensure protection from abuse.

Some improvements were needed to the building to ensure it was safe and homely for everyone.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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

The service was not always safe. Staff had assessed risks to each person's safety and any risks they posed to other people but there had been occasions where people had not been protected from risk of harm. Financial processes were not robust enough to protect people who could not manage their own finances.

Staff knew people's needs well but there were not enough permanent qualified, skilled and experienced staff employed to meet people's needs.

Staff were safely recruited. Staff had good knowledge of whistleblowing and safeguarding procedures and knew how to raise concerns to protect people in the home from unsafe care.

There were effective systems in place to monitor people's medicines to make sure staff gave them safely.

Health and safety building checks had not always identified where improvements were needed.

Is the service effective?

Good

The service was effective. People received support to make their own decisions and where they did not have capacity to understand, processes were in place to ensure those who cared for them made decisions in their best interests.

Staff supported people with eating. Staff supported people to see healthcare professionals, such as GPs, psychiatrists, opticians and dentists regularly though one person had unmet health needs.

Is the service caring?

Requires improvement

The service was caring. Permanent care staff demonstrated good understanding of people's care and support needs and knew people well. There was a relaxed atmosphere where staff and people living in the home laughed together. Staff respected people's different personalities and backgrounds but did not consistently engage with people in a person centred way.

The home was wheelchair accessible which was important for one person's independence. There was a lack of privacy due to limited communal space and people not being able to lock their bedrooms

Is the service responsive?

Requires improvement

The service was not always responsive. People's care plans were comprehensive and they were updated regularly to reflect any changes in their

Summary of findings

care and support needs. Each person had an individual weekly programme of activity in accordance with their preferences. The service was not consistently person centred in terms of how people spent their time and the goals in their care plans.

People were given information on how to make a complaint and systems were in place to appropriately respond to complaints.

Is the service well-led?

Requires improvement 

The service was not consistently well led. The registered manager had been away for three months shortly before the inspection so there had been temporary management arrangements in place. Staff morale at the time of the inspection was negatively affected by recent changes in staffing and the manager's temporary absence.

The systems for monitoring quality identified any weaknesses. Where improvements were needed, these were followed up by Choice Support. Monitoring visits ensured improvements were implemented and sustained.

Staff said they felt able to approach the registered manager for advice and support. There was a lack of management support for the registered manager at the time of the inspection as there were no senior staff and the registered manager was responsible for managing two care homes.

Choice Support - 18 Varty Road

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 29 May 2015 and was unannounced. The inspection was carried out by one inspector.

Before the inspection we reviewed information from notifications sent to us by the provider and safeguarding alerts for the last year.

We used a number of different methods to help us understand the experiences of people living in the service. We spent time observing how staff interacted with the four people living in the home

in the communal areas such as the lounge, office and kitchen. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We met the four people living in the home and talked to two of them.

We were able to speak with a relative or professional for each person living at the home. We interviewed the manager and three staff on duty. We used pathway tracking (where we read a person's care plan then checked to find out if staff were following the care plan to meet their needs). We looked at two people's care records in detail. We checked food records, two staff

files, staff duty rosters, staff training, recruitment, supervision, appraisal and meeting records, accident and incident records, risk assessments, health and safety records, financial records for two people, selected Choice Support policies and procedures and medicine administration records.

Requires improvement

Is the service safe?

Our findings

All four people living in the home had communication difficulties and were not able to tell us if they felt safe in the home. One person was able to say, "it is alright, it's a bit alright here." People's representatives told us that they would be able to tell by a person's behaviour if they were unhappy and they thought people were happy in the home.

When we looked at care plans we found they contained detailed information about "keeping me safe" for each person. This information included risks to the person's safety and information on their behaviours which were a risk to themselves and others. It advised staff how to keep the person safe from harm and how to make them feel safe. The advice had been updated when people's needs changed.

The provider's financial practices did not always protect people from the risk of financial abuse. One employee was the only signatory for the bank accounts for three of the people in the home which was not in accordance with the provider's policy.

The provider's holiday policy was not adhered to. The policy stated that staff were not paid more than their contracted hours when on holiday with people who used the service. It also required people to pay for staff accommodation, travel, insurance, subsistence and entrance fees. In practice, records showed that they also paid for extra hours and night duties staff worked to support them whilst on holiday. In some cases this was a substantial amount of money. Best interests meetings were held to ensure people's representatives helped to make decisions for them about going on holiday. However, although these meetings recorded that the person would pay a contribution to staffing costs, they did not detail the costs involved. There was no written evidence that the person who used the service or their representatives knew how much money the person would be charged by Choice Support to pay for staff costs to support them on their holiday.

One person's representative told us they had seen the invoice detailing the amount the person was charged at a later stage. We were unable to contact the other representative, but there was no written evidence available to confirm they knew the actual cost when they agreed to the holiday. Although this was not evidence of misuse of people's money, it is not good practice to commit people to paying for services when the costs are not made clear in advance and could leave them at risk of financial abuse.

There had been some incidents in recent months where people were not safeguarded from harm,for example one person was locked in their room at night by staff and one person assaulted another.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person had unexplained bruising that staff had not noted and reported promptly. In each case, Choice Support had taken steps to ensure the person was alright, to remind staff about what was expected of them and to take appropriate action where staff had not followed proper procedures. The safeguarding and reporting policies were clear and the provider ensured all incidents were reported to the local safeguarding authority.

The house had only one communal room for all four people which exacerbated the risk of incidents between people. Staff took the action they could to minimise the risks of these incidents happening again, such as ensuring certain people were not left alone together without staff present. However there was insufficient action to ensure people's safety and privacy at night. Although there were alarms on the doors to alert staff when someone had left their bedroom, night staff were based downstairs so they were not always able to prevent somebody going into another person's room. People did not have suitable safe locks on their bedroom doors to prevent other people from entering their room.

The above was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a policy about safeguarding people from abuse which was in a folder and staff had signed that they had read it. Staff understood the organisation's whistleblowing policy well. They confirmed information about how to raise concerns about poor practice confidentially was provided to them. We saw written records showing that the safeguarding and whistleblowing procedures had been explained to staff recently in meetings. Staff were clear that they could raise any concerns with the registered manager, but were also aware

Requires improvement

Is the service safe?

of other organisations with whom they could share concerns about poor practice or abuse, such as the local authority, police or Care Quality Commission. Choice Support trained staff in safeguarding adults from abuse.

Choice Support had taken appropriate disciplinary action in cases where a staff member had not acted appropriately to ensure people in the home were protected from risk of abuse or unsafe care.

Staffing levels were satisfactory to meet people's needs but not enough permanent staff who knew people's needs were available so bank and temporary staff were used to ensure there were always enough staff on duty to meet people's needs.. There were two staff working on weekday mornings to support people to get up and get ready to go out to their daytime activities and to support the person who stayed at home all day. In the evenings and at weekends there were three staff on duty so that there were enough staff to support people to go out when they wanted to. At night there was one staff member awake and one asleep in the building in case of emergencies. At the time of the inspection the service did not have enough permanent staff so at times people were supported by staff who did not know them well. There was no evidence of any negative impact on people but one staff member told us that some people did not feel comfortable with staff they did not know. We discussed this with the registered manager who said that Choice Support were in the process of recruiting new staff for this home.

Staff had been trained in giving people their medicines safely. Each person had a medicines profile listing each of their medicines, what it was prescribed for and possible side effects. There were clear guidelines for staff on when to give medicines that were prescribed "as and when needed." People's medicines were obtained and stored safely. Staff had received medicines training and their competency had been assessed. One staff member told us they were not giving people medicines as they had not yet been assessed for competence by the manager. This was safe practice. We looked at a sample of medicines administration records and found two errors where staff had signed to confirm a medicine was given before they had given it. These errors did not have any impact on people and there was no evidence that people did not get their medicines as prescribed. We reported this to the manager and this was addressed during the inspection. One person was refusing their prescribed medicine and the service had reported this to their healthcare team appropriately.

The lounge was safe and homely. Two bedrooms were also homely and well maintained, but the other two bedrooms were not in a satisfactory condition. One had damage to the walls from mobility equipment and the other had untreated damp which had not been assessed for potential risk to the person's health. Health and safety audits were undertaken to identify any risks but these had not highlighted the damp issues. We observed the weekly health and safety check taking place. Staff checked water temperatures, fire callpoints to ensure the fire alarm was working, front door keypad and equipment in the home such as wheelchairs, walking frames and sensor mats. There were some omissions. We noted from our inspection of the building that two fire doors were not self closing and this had not been identified by the weekly check carried out by staff or the Choice Support check. The registered manager told us this was due to new flooring which had made the doors difficult to close. She agreed to request an urgent adjustment to the fire doors.

We noted that the provider's quality checkers had reported in June 2014 that radiator covers needed to be painted or replaced but this had not been done. There was water damage to the corridor from a previous leak that had not been treated.

Remedial work had been carried out to reduce risk of legionella in the water supply but a new certificate had not been issued to say that the service had now met the requirements to manage risk of legionella .

The above concerns were a breach of Regulation 15 of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.

Checks of the fire equipment, fire alarm system, emergency lighting, gas, boiler, electrical appliances and wiring had all been carried out in 2014 and all passed the inspections.

Good

Is the service effective?

Our findings

The provider operated a comprehensive training programme for staff which included all training areas necessary to meet the needs of people in the home. More specialist training for meeting individual needs was provided by district nurses and the provider's positive behaviour support team. The training was repeated regularly to ensure staff kept up to date with their knowledge. We spoke to two staff about the training provided and both said they thought they had enough training to meet people's needs.

Permanent staff received individual supervision sessions regularly and the goals set at their annual appraisals were discussed in supervision sessions. The most recent appraisals were not available for inspection but the the registered manager told us they had been carried out and were being approved by a senior manager. The registered manager also carried out practical observations of staff working and gave them feedback on how they could improve their practice. We looked at one of these records and it was comprehensive. A staff member told us they could also request a supervision session if they had any concerns to discuss with the manager.

Staff had an understanding of the Mental Capacity Act 2005 and how to ensure the rights of people with limited mental capacity to make decisions were respected. People had a care plan in relation to their capacity and ability to consent. These plans considered how people could be involved in making decisions about their care and who they might like to support them with this process and the best times and circumstances to ask them to make a decision. The service provided information for people in a format they could understand so that they could make an informed decision, for example, there were pictorial leaflets about medical examinations. This was good practice in supporting people to make decisions. Best interests meetings were held when an important decision was needed and the person was unable to understand. This process involved people who knew the person well.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. The registered manager was trained to understand when applications for DoLS should be made, and in how to submit one. People in the home were deprived of their liberty. They were unable to leave the home without staff support as there was a keypad on the door which they were unable to use. The reason for this was that people in the home were assessed as being at risk of harm if they went out alone. The registered manager had applied for and received deprivation of liberty safeguards authorisations to ensure this restriction was lawful. When people wanted to go out they could tell staff verbally or show them by fetching their coat or taking staff to the front door.

Support plans explained people's ways of communicating and explained what certain behaviours meant for each individual. This helped staff understand people better.

There was a book of food photographs in the kitchen so people could point to photographs if they were not able to speak or sign to staff what they wanted to eat. Staff involved people in making their own drinks. Three of the four people had specific needs in relation to eating, such as risk of choking. A choice of main meal was not offered but staff said the menu was based on what they knew people liked, adjusted to meet their specific dietary needs. One person liked to eat different meals to the others and this was respected. Staff encouraged people to eat a healthy balanced diet but also respected their preferences.

Staff supported people with their health needs. One person had a specialist health need that staff were able to support as they had received specialist training. Staff supported people to go to the GP for annual health checks and visit the dentist, optician and appropriate healthcare professionals where needed. Each person had a health action plan detailing their health needs and a hospital passport which included important information about them and their health so that hospital staff would be able to look after them in the event of them being admitted to hospital. Staff could refer to detailed records which explained how to assess pain levels if a person could not tell them. Staff told us the signs they would look out for and knew what action to take for each person when they showed signs of being unwell.

One person had a health need which had not been met as they did not like going to the GP and staff were trying to

Good

Is the service effective?

encourage them to do so. We discussed this person's unmet health need with the registered manager who was able to inform us of what action the service planned to take in order to address this person's unmet need.

The service had been unable to weigh one person for 22 months despite clear evidence that they were experiencing problems with maintaining a healthy weight. The person was not receiving any support with this but a healthcare referral had been made for them.

Requires improvement

Is the service caring?

Our findings

Three people had family who they kept in contact with. Staff supported them to visit family and involved their families in making decisions about their care. We were able to speak to one person on behalf of each person living in the home. They all said that staff were caring and people were happy there. There was mixed feedback about communication. Two people said staff informed them of important information and one said staff had not informed them of an important event affecting one person's wellbeing. One representative said that everything was fine and they had no problems with the way staff cared for people.

We observed three staff members interacting with people who lived at the home. We found that staff knew each person's preferences well in respect of their daily routine. Routines were important to some people and staff supported their need to follow their own routine. For example, one person liked to go to the shops every day and another had very specific food preferences. Permanent staff were very knowledgeable about these preferences.

Staff were kind and affectionate and there was a homely atmosphere, but during our observation interaction was mainly based around tasks such as making a drink and we did not see staff sitting with a person just engaging and spending time with them.

The registered manager was a good role model in demonstrating respectful, meaningful communication with people in the home. Care plans showed detailed information about people's preferred methods of communication which ranged from speech to choosing between pictures and signing.

Staff said nobody had any religious or spiritual needs. People did not have privacy in their rooms as they were not able to stop anyone from coming into their room. The provider was appointing a staff member as a dignity champion to help ensure staff treated everyone with dignity.

We recommend that the service seeks advice and guidance from a reputable source about best practice in engaging with people who have communication difficulties.

Requires improvement

Is the service responsive?

Our findings

We asked a representative for each person in the home (relative and professional) whether they thought the service met people's individual needs and wishes. All said they thought the person was happy in the home and that the service was generally responsive to individual needs.

Each person had a detailed support plan setting out their needs in a person centred way. Support plans took into account the person as an individual, their abilities, strengths and needs and their wishes. Plans were updated when people's needs and wishes changed. Staff knew people's wishes and responded quickly to their needs.

Although support plans were detailed some staff did not always understand person centred goals. Goals which had already been achieved were still listed, for example, one person regularly went to a weekly disco, but this was still listed as something to work towards. In another case the goal was "to listen to staff when they are talking to me" which looked more like staff aspiration than a goal the person would have chosen themselves.

Three people attended a day service five days a week. The other person was at home.

One representative said they thought the person did not go out as often as they would like and did not have opportunity to do more interesting things.

We spent time observing staff interactions with people in the home. We saw one person spent a long period of time with little choice of things to do. Another concern was that one person had a car but only one part time staff member was able to drive it which limited the person's opportunities to go out and do things they enjoyed. The registered manager told us they were trying to recruit a driver. In the meantime, this person's social life was being affected by not being supported to go out every day.

People were supported to do things they enjoyed but the range of activities available to people had not changed for some time. Staff supported people with activities in their personal care plans such as visiting local shops, meals out, visiting family, having a massage from a visiting therapist and going to a nail salon. There were limited opportunities for people to engage in new meaningful activities. We saw one person sat for three hours with a book but no other activities or engagement with staff was offered to them.

There was only one communal room and this, with a lack of individual activity within the home, meant that people were together in close proximity and they did not always like this.

Staff supported three people in the home to go on holiday every year and the fourth person did not want to go on holiday. People were unable to tell us their views, but their representatives told us that people really enjoyed going on holiday.

Each person had a risk assessment and guidelines to support them with their behaviour when it challenged the service. Staff followed the guidelines. One person had complex needs and their needs were not being fully met at the time of the inspection. We discussed this with the manager who told us they had already sought specialist support and were requesting help with this person's needs.

One person did not have enough clothes that fitted them properly. This person was wearing illfitting clothes which affected their dignity. A professional involved with this person also commented on this being a regular occurrence. The service had not been able to address this issue effectively.

There had been no complaints recorded in the last year. A relative confirmed the registered manager had sent them a copy of the complaints policy so that they knew how to complain. They said they had no complaints. There was a complaints procedure in plain English and pictorial form available for people who used the service to understand how to complain. There had been an occasion where one person living in the home had complained and staff had taken the complaint seriously and resolved it to their satisfaction.

We recommend that the service seeks guidance from a reputable source to improve person centred care.

Requires improvement

Is the service well-led?

Our findings

This home had a registered manager but at the time of this inspection this person had been away for three months and had only recently returned. Other Choice Support managers had shared the management of the home while the registered manager was away. This had been a disruptive time for staff and people living in the home but Choice Support tried to keep things running smoothly and gave regular updates to the Care Quality Commission.

The registered manager did not have a deputy manager or any senior staff to support her with management duties despite her being the registered manager for two homes. We raised this concern at the inspection and we were informed that a few days later the deputy manager from another Choice Support home, who already knew this home, began working at the home two days a week to support the registered manager.

Two representatives told us that the registered manager listened to people's views and worked hard to provide a good quality service to individuals in the home. One said that the manager had done everything she was asked to do and was always available to discuss people and give advice. They thought she was thorough,responsiveand dedicated. One said the registered manager rectified any problem quickly.

Staff morale was negatively affected by recent disruptions to the service where the manager and two permanent staff had been away from the home. There was a continuing reliance on temporary staff due to insufficient permanent staff being employed.

We looked at the annual audit of the home carried out by Choice Support. We saw that some recommendations had been made to improve the service provided to people. Choice Support employed "quality checkers" and they wrote an "easy read" version of the last audit of the home, using pictures and symbols which can be used to help people who do not read written English. This enabled the report to be understood by people living in the home as well as staff.

Choice Support sent out an annual survey to people using their services.This was written in Plain English and had photographs and pictures to help people understand it and was evidence that Choice Support sought the views of people using the services.

Choice Support was signed up to the 'Driving up Quality Alliance Code'.This code is one of the responses to the abuse that took place at Winterbourne View, a private hospital for people with learning disabilities.The code aims to protect people and improve the quality of their services.Choice Support had invited families of people in this home to attend a meeting and give their views.

Two representatives of people living in the home thought that communication between day services and the care home could be improved as staff in the care home did not always notifiy the day service of incidents affecting a person's wellbeing. They also mentioned that staff did not always ensure people were appropriately dressed and with all the items they needed for their personal care during the day.

Record keeping was satisfactory and the standard of records was sufficient to see what care people needed and what care they had received. The support plans and care records were not all consistently written to a high standard but Choice Support's own audits were thorough, highlighted any areas that could be improved and set out actions for the registered manager to follow. An audit in March highlighted a need for improvement in ensuring a positive person centred culture. The audits were based on best practice. There was a service development plan detailing improvements planned to the service in the next year. This was evidence of good governance by Choice Support of this care home.

We recommend that the service seeks advice and guidance from a reputable source to review its management arrangements to ensure sufficient management support is available at all times.

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 (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The registered persons had not assessed all the risks to the people's health and safety and done all that is reasonably practicable to mitigate any such risks. Regulation 12 (1)(2)(a)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: Systems and processes for the prevention of financial abuse were not robust enough to protect people from the risk. Regulation 13(1)(2)(6)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 15(1)(e).

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.