Choices Housing Association Limited

Choices Housing Association Limited - 1 William Street

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service on 31 August 2017. This was an unannounced inspection. At our previous inspection in September 2015, we found that the service met the legal requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

The service had 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 and associated Regulations about how the service is run.

We found that improvements were needed to ensure that people consistently received safe care. This was because; local and national safeguarding guidance was not followed to ensure people were protected from the risk of abuse and neglect. Concerns were also identified in regards to the recording of medicines administration, night time staffing levels and access to on call management cover.

Improvements were also needed to ensure that the systems in place to assess and monitor the quality and safety of care were consistently effective and notifiable incidents were not always reported to us.

We found that staff were recruited safely and they received regular training that provided them with the knowledge and skills to meet people's needs.

People's health and wellbeing needs were monitored and people were supported to access health and social care professionals as required. People could eat meals that met their individual preferences.

Staff supported people to make decisions about their care and when people were unable to make these decisions for themselves, the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) were followed to ensure people's rights were protected.

People were treated with care, kindness and respect and staff promoted people's independence and right to privacy.

People were supported and enabled to make choices about their care and the choices people made were respected by the staff.

People were involved in the assessment and review of their care and staff supported people to access the community and participate in activities that met their individual preferences.

Staff sought and listened to people's views about the care and action was taken to make improvements to their care. People understood how to complain about their care and a suitable complaints procedure was in place.

People and staff told us that the registered manager was supportive and approachable.

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. Local and national systems in place to safeguard people from abuse and neglect were not always followed.

Staff were recruited safely and staffing numbers were flexible during the day to ensure people's needs were met in a safe manner. However, concerns were raised about night time staffing and the variable access to the provider's on call systems.

Medicines were stored safely. However improvements were needed to ensure accurate medicines records were maintained.

Risks to people's health, safety and wellbeing were assessed and planned for.

Is the service effective?

Good

The service was effective. People were supported to eat meals that met their individual preferences.

People's health needs were effectively monitored and managed and staff were suitably skilled to meet people's individual care needs.

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

Is the service caring?

Good

The service was caring. People had positive relationships with the staff and staff treated people in a caring manner.

People were treated with dignity and respect and their right to privacy was promoted. People were supported to make choices about their care and independence was promoted.

Plans were in place to enable people to receive person centred end of life care when this was needed.

Is the service responsive?

Good

The service was responsive. People were involved in the planning and review of their care.

People were supported to participate in activities that met their individual interest and preferences.

People were offered the opportunity to share any concerns or complaints about their care. A complaints system was in place to manage any potential complaints.

Is the service well-led?

Requires Improvement 

The service was not consistently well-led. Notifiable incidents were not always reported to us as required. Systems were in place to assess, monitor and improve the quality of care. However, these systems were not always effective.

Feedback from people and their representatives about the running of the home was sought and acted upon to improve the quality of care.

The staff demonstrated they had caring values and they were supported by the registered manager who assessed and monitored their development needs.

Choices Housing Association Limited - 1 William Street

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 – 1 William Street on 31 August 2017. 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 three people who used the service and a relative of a person who used the service. We also reviewed written feedback sought by the provider from people's relatives about the care. We did this to gain people's views about the care and to check that standards of care were being met. We spoke with three members of care staff and the registered manager. We did this to gain their feedback about the care and to check they knew how to keep people safe and meet people's needs.

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.

Requires Improvement

Is the service safe?

Our findings

Staff told us how they identified, recorded and reported potential abuse. Local and national safeguarding guidance states that incidents of alleged abuse should be immediately reported in order to safeguard people from further potential abuse. However, we identified at four incidents of potential abuse and/or neglect that had not been reported to the local safeguarding team as required. These incidents related to an omission of care that resulted in injury to a person who used the service and an incident of unexplained bruising. Incident records showed that the registered manager and provider had reviewed these incidents. However, safeguarding referrals had not been raised or discussed with the local safeguarding team. The registered manager told us they had not reported these incidents as they did not feel they were incidents of intentional abuse. This showed that the registered manager and provider did not follow safeguarding procedures to report incidents of potential abuse and neglect as required. This left people at risk of harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People told us that staff were always available to provide them with care and support. A relative also confirmed this by saying, "There are always staff here when I come to visit". The registered manager told us that staffing numbers changed dependent upon activities and appointments and we saw that this was reflected in the staff rotas. We saw there were adequate numbers of suitably skilled staff available to support people with their needs during the day. However, care records showed and staff told us that there were some concerns around how one person who used the service was supported at night when only one staff member was available. This person's care records showed they required two staff members to support them to move during the day. However, their care plan stated that one staff member could provide this support during the night. This person's care records showed and staff we spoke with confirmed that this person's ability to move at night was variable. For example, recorded comments from night staff included, 'very poor transfer' and, 'unsteady on transfer'. This person's records also showed they had recently fallen when they were supported to move by one staff member during the day as they declined to wait for a second staff member. This incident and the person's variable mobility had not triggered any changes to the staff numbers at night. This meant we could not be assured that this person was in receipt of safe care and support during the night when only one staff member was available.

Care records showed and staff also told us about a recent incident that had occurred during the night where the provider's on call system had failed. Care records showed that a staff member attempted to contact the on call manager and provider on multiple occasions during a night shift in response to an incident that had occurred at the service. This staff member had been unable to speak with the on call manager or provider which meant they had not been able to gain the support they required. This meant that improvements were needed to ensure lone working staff could seek support out of hours in the event of an incident or emergency situation.

We saw that medicines were stored safely and we observed staff members administering people's medicines in a safe and caring manner. Protocols were in place that provided staff with the guidance needed to administer people's 'as required' medicines safely and consistently. However, we found

inaccuracies in the numbers of medicines in stock and the numbers of medicines recorded on some people's medicines administration records. These inaccuracies meant people who used the service could not always be assured that they had received their medicines as prescribed. This meant that improvements were needed to ensure medicines administration was accurately recorded.

People's care records showed that risks to their health safety and wellbeing had been assessed and planned for. For example, people's risk of choking was assessed and when a person was identified as being at risk of choking, appropriate plans were in place to guide staff in how to manage this risk. Staff showed they had a good understanding of how to manage people's risks as the information they gave us about people's risks matched the information in people's care records.

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. We saw that people were happy and comfortable around the staff. This was evident because people were smiling around the staff and they approached staff with ease.

Good

Is the service effective?

Our findings

People told us and we saw that they could choose the foods they ate. For example, one person told us they liked to eat cheese on toast. We saw a staff member ask this person what they wanted to eat for their breakfast. This person asked for cheese on toast and this was provided for them. Staff also asked the person if they would prefer white or brown bread to ensure their personal food preferences were met. People also told us they could access snacks and drinks when they wanted them and we saw that this was the case as people were provide with drinks throughout the day. We also saw that people's specialist dietary needs were met in an inclusive manner. For example, food that was pureed or modified was made to look like the original food items they had been modified from. This ensured people were served with food that looked appetising and well presented.

Staff demonstrated that they understood how to support and monitor people's health and wellbeing. For example, one person showed us a bruise they had sustained on their hand. They told us, "I knocked it on the door". The staff had documented the location of the injury in the person's care records on a body map, so the bruise could be monitored for any changes. Another person who used the service had a plan in place that stated a specific health need needed to be monitored to help manage their health and wellbeing. We saw that a resources were in place that enabled staff to monitor this person's health needs in accordance with their plan. This ensured the person's health needs were monitored and managed effectively.

People told us and we saw that they were supported to access health and social care professionals as required. For example, one person's care records showed multiple entries confirming they had recently been supported to access doctors, a dietician and a dentist.

People's relatives had confidence in the staffs' knowledge and skills. A relative told us, "They seem to know how to handle [person who used the service] and they are very knowledgeable". Another relative had fed back the following comment in a recent satisfaction survey, 'The home has a well-balanced staff team in place with a good range of skills'. Staff told us and training records confirmed they had received training to enable them to meet people's care needs. One staff member said, "I've learned about wheelchairs, hoisting and pureed diets since working here. It's really good as I had never worked in the physical health side of care before I came here". We saw this training had been effective as we observed this staff member support people with their mobility and dietary needs in a safe and effective manner.

We saw that staff supported people to make every day decisions about their care. For example, people were supported to choose what to eat and drink and the decisions people made were respected. Some people were unable to make important decisions about some of the more complex decisions relating to their care. We found that in these circumstances the staff followed the requirements of the Mental Capacity Act 2005 (MCA). 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. For example, one person's care records showed they were able to consent to live at the service, but they needed

support to make decisions about their finances as they had a limited understanding of money. A plan was in place to ensure this person received appropriate support with their finances in their best interests.

Some people who used the service had restrictions placed on them to promote their safety and wellbeing. For example, some people could not leave the service unsupervised due to the potential risk of harm to them from the external environment, such as traffic. 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). We found that the restrictions placed onto people had been made in accordance with the MCA and DoLS. Staff demonstrated they understood the reasons for people's DoLS applications and authorisations.

Good

Is the service caring?

Our findings

People told us they liked living at William Street and they liked the staff who supported them. Comments from people included, "I like living here" and, "I like the staff". A relative we spoke with told us they were confident that their relation was happy living at William Street. They said, "I know by [person who used the service's] smile that they are happy here" and, "I know he's loved here".

People told us and we saw that people had positive relationships with the staff. This was because staff knew people very well. For example, one staff member introduced us to a person who used the service and helped this person to tell us what their hobbies and interests were. The staff member told us the person enjoyed going to concerts which then prompted the person to tell us about a recent concert they had attended. A relative we spoke with also confirmed that the staff had a good knowledge of people's likes, dislikes and care preferences.

Feedback from relatives showed that they believed that their relation's dignity was promoted. For example, one relative had made the following comment, "[Person who used the service] is always very smartly dressed, clean shaven and their hair is always lovely. The staff are very caring". We observed that people's dignity was promoted and maintained throughout our inspection. For example, we saw that when a person's relative asked for a photo to be taken with their relation, a staff member asked the person if they would like their protective apron removed as they were wearing this whilst they were being support to have a drink. They then asked the person if they would like the apron back on after the photo had been taken. This showed that the staff member had promoted the person's dignity and involved them in making choices about their care.

People were supported to be as independent as they could be. For example, we saw that where appropriate people were enabled to participate in meal and drink preparation. The people we spoke with told us they enjoyed being able to do these tasks.

We saw that systems were in place to help people to be involved and understand their care. For example, we saw that a pictorial document was used to help people understand dignity and what this meant for them. Staff also had a good understanding of people's communication needs. For example, staff could interpret people's restricted speech to enable them to have meaningful conversations with them. Detailed communication care plans were in each person's care plans. These provided guidance about how each individual communicated their needs. This meant staff had access to and followed people's communication care plans.

We saw that relatives were welcomed to the home and events were held at the service that relatives were encouraged to attend. For example, we saw photos of a garden party that was held for people and their relatives at the service. This meant people were supported to maintain relationships with their families.

People could access private areas of the home when they wished to do so. For example, we saw people went to their bedrooms when they wanted to spend time alone and staff respected people's right to privacy.

People's care plans recorded their end of life preferences. These plans were centred around the individual needs and preferences of each person. For example, they contained details of how the person would like to be dressed if they wished to be buried. This meant that information had been obtained to ensure it could be accessed to provide person centred end of life care when this was needed.

Good

Is the service responsive?

Our findings

People and their representatives told us and care records showed that people were involved in the planning of their care. One person's care records showed they had asked to see some animals during a planning meeting. Their care records showed they had been supported to visit Chester zoo in response to their request. Another person's care records clearly recorded their preference to have seven sprays of aftershave applied during personal care. Staff demonstrated they were aware of this person's care preferences which meant they had the information they needed to meet the person's care preferences in a consistent manner. One person's relative also confirmed they were involved with care planning. They said, "[Person who used the service] can't tell us what he wants to do. I am involved, but I don't feel I need to be now as they know him so well".

People and their representatives also told us and care records showed that they were involved in the review of their care. For example, one person's care records showed that they and their relative had recently been involved in a review of their care. This review showed that feedback was sought from the person and their relative. The records of the review confirmed that the person was happy with the care they received, but some changes to the care plan had been made as a result of the review to reflect a small change in the person's preferences. The person had signed the review records to confirm they had participated in their review. This showed that people's care needs and preferences were regularly reviewed and their plans were updated in response to changes in people's preferences and needs.

People and their representatives told us that they were supported to access the community to participate in activities that were important to them. One of the tools used to enable staff to identify which activities people wanted to participate in was called, 'Make a wish' which recorded the activities people wished to experience. Staff then worked with people to ensure their wishes were granted. One person told us, "I like going to concerts. I went to a concert to see [a tribute act] and I'm going to see [names of three acts] soon" and, "I'm going out twice today". Another person's representative said, "[Person who used the service] goes on trips and goes to clubs". Care records also showed that people were supported to participate in activities in the community that were meaningful to them. For example, one person's care records showed they liked activities that were related to war. Their care records showed they were regularly supported to visit a local war memorial and a museum where they could see a Spitfire.

People and their representatives told us they knew how to complain about the care. One person said, "I'd tell [named keyworker] or [pointed to the registered manager]". A relative told us, "I would approach the manager if I needed to make a complaint. I've never needed to, but I know what to do". Records showed that people were regularly asked if they were happy with their care during meetings with staff. This provided people with regular opportunities to share any concerns or complaints about their care. There was a complaints procedure in place. This included a pictorial/easy read complaints guide. No complaints had been made at this service since our last inspection.

Requires Improvement

Is the service well-led?

Our findings

We found that the registered manager and provider had not reported some notifiable incidents of alleged abuse to us as required. We identified at least two incidents of potential abuse and/or neglect that had not been reported to us as required. These incidents related to an omission of care that resulted in injury to a person who used the service and an incident of unexplained bruising. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Quality checks were completed by the management team, provider and external agencies. These included checks of medicines management, health and safety and care records. Some of these checks had resulted in improvements to care. For example, an audit of refrigerator temperature monitoring had identified that improvements were needed to ensure this was completed consistently and effectively. Records showed these improvements had been made as refrigerator temperatures were now being effectively monitored. However, some of the checks had not identified some of the concerns we found. For example, medicines audits had not identified the recording and stock errors that we identified. This meant that improvements were needed to ensure monitoring systems were consistently effective in assessing and improving quality.

People and staff told us they were supported by the registered manager. One person said, "I like [pointed to the registered manager]". Staff described the registered manager as; "Helpful", "Brilliant" and "Professional". Staff told us that a system was in place that enabled them to receive supervision so that their competencies and development needs could be assessed and monitored. All the staff we spoke with told us that supervision sessions were very valuable to them. For example, one staff member said, "It's good to reflect on what I'm doing so that I know if I am doing anything wrong".

People and their relatives were enabled to be involved in the running of the service. We saw that a system was in place to involve people and their relatives in the recruitment of new staff. This system that ensured people were asked about the qualities and characteristics that new staff members should possess. This showed that the management team recognised that people had a part to play in the running of their home.

Records showed that feedback from people and their representatives was used to improve the quality of care. For example, a satisfaction survey from people's relatives showed that some relatives were not aware of the formal complaints procedure at the service. This led to the registered manager sending out this information to people's relatives so they had the information they needed to raise a complaint if required. A relative we spoke with confirmed they had a copy of the complaints procedure, which showed effective action had been taken by the registered manager to resolve this issue.

There was a positive and homely atmosphere at the service. One person's relative confirmed this by saying, "It's home from home for [person who used the service]". Staff told us that they enjoyed working with people who used the service. Comments from staff included; "I love it, every day is different and I like helping the guys here" and, "I love caring for the people here and I make sure they have a good life. I treat them how I'd want a family member to be treated". It was evident that staff had caring values as we observed positive interactions from all the staff we observed during our inspection.

The results of a relatives satisfaction survey also showed that relatives were satisfied with the care their relations received at the service. 100% of the respondents to the survey gave an excellent overall rating regarding the quality within in the home.

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 18 Registration Regulations 2009 Notifications of other incidents We were not always notified of incidents of potential abuse.

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 This showed that the registered manager and provider did not follow safeguarding procedures to report incidents of potential abuse and neglect as required. This left people at risk of harm.