Auditcare Mon Choisy Limited

Mon Choisy

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

This inspection took place on 30 November 2016 and 5 December 2016. It was an unannounced inspection.

Mon Choisey is registered to provide accommodation for up to 28 older people who require personal care. At the time of the inspection there were 21 people living at the service.

At the previous inspection on 19 October 2015 we found that people's care plans did not always contain information guided by the principles of the Mental Capacity Act 2005 (MCA). This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

We also found that the registered manager had not taken reasonable steps to mitigate the risks to the health and safety of service users receiving care. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

At this inspection we found that the home had made some improvements to address the areas of concern and start bringing the service up to the required standards.

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 2008 and associated Regulations about how the service is run.

The service had introduced mental capacity assessments for people who may be deemed as lacking capacity to make certain decisions. These capacity assessments included information that was guided by the principles of the MCA. However, staff did not always follow the principles of the MCA.

Appropriate contingency plans were not always actioned in the event of an untoward event that impacted on the service..

People received their medicine as prescribed. However, staff did not always follow the providers protocols when administered 'as and when required' medication.

Where risks to people had been identified risk assessments were in place and action had been taken to reduce the risks.

The registered manager had not always notified CQC of reportable events. Audits were conducted to monitor the quality of service. However, these audits were not always effective and did not identify the concerns we found.

There were sufficient staff to meet people's needs. Staff were not rushed in their duties and had time to chat

with people. Throughout the inspection there was a calm atmosphere and staff responded promptly to people who needed support. The service had robust recruitment procedures and conducted background checks to ensure staff were suitable for their role.

People were confident they would be listened to and action would be taken if they raised a concern. People told us the service was responsive and well managed.

People received person centred care. People were cared for by a service that understood the importance of getting to know the people they supported. People had access to meaningful activities.

People told us they enjoyed the food provided by the home. Where people required special diets these were provided by a chef who clearly understood the dietary needs of the people they were catering for.

Staff spoke positively about the support they received from the registered manager. Staff had access to effective supervision.

We found two 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 this report.

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 did not always follow the providers protocols when administering 'as and when required' medication.

There were sufficient staff on duty to meet people's needs.

Staff understood their responsibilities to identify and report all concerns in relation to safeguarding people from abuse

Is the service effective?

Good

The service was effective.

Plans to support people's care during disruptions to the service were not always actioned.

People had sufficient to eat and drink and were supported to maintain good health.

Staff had the training, skills and support to care for people.

Is the service caring?

Good

The service was caring. Staff were kind and respectful and treated people with dignity and respect.

People benefited from caring relationships.

The staff were friendly, polite and compassionate when providing support to people.

Is the service responsive?

Good

The service was responsive. People's needs were assessed to

ensure they received personalised care.

Staff understood people's needs and preferences. Staff were knowledgeable about the support people needed

There were activities for people to engage with.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager had not always notified CQC of reportable events.

Audits were conducted to monitor the quality of service. However, these audits were not always effective.

There was a whistleblowing policy in place that was available to staff around the home. Staff knew how to raise concerns.

Mon Choisy

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 checked 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.

This inspection took place on 30 November 2016 and 5 December 2016 and was unannounced. The inspection was carried out by two inspectors and an expert by experience (ExE). An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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 looked at previous inspection reports and notifications received from the provider. A notification is information about important events which the provider is required to tell us about by law. This ensured we were addressing any areas of concern.

We spoke with seven people, three relatives, six care staff, the chef, the registered manager, the nominated individual, and two healthcare professionals. We reviewed six people's care files, six staff records and records relating to the management of the home. Prior to the inspections we spoke to commissioners of the home to get their views on the service is run.

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.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection on 19 October 2015 we found that the registered manager had not taken reasonable steps to mitigate the risks to the health and safety of service users receiving care. Thickening powder that was prescribed to be used as part of the treatment for people with swallowing problems was not stored in line with safe storage guidance. People were not always protected from untoward events and emergencies. People were not always protected from the risk associated with their environment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

At this inspection we found that the home had made improvements to address the areas of concern and bring the service up to the required standards. For example thickening powder that was prescribed to people with swallowing problems was stored in line with safe storage guidance. Staff we spoke with aware of this guidance and told us they followed it. We spoke with the senior carer on duty and they were aware of the national safety patient alert surrounding the safe storage of thickeners. Patient safety alerts are a crucial part of the NHS to rapidly alert the healthcare system to risks and provide guidance on preventing potential incidents that may lead to harm or death. They told us it was recommended that (thickeners) should be treated as a medicine following the safety alert".

The service had also made improvement to ensure that people were protected from untoward events and emergencies. For example, a 'grab box' (A box containing personal evacuation plans, designed to be easily accessible in the event of an untoward incident) was stored in an area of the home that was easily accessible to staff in the event of an emergency.
Staff administering medicines checked each person's identity and explained what was happening before giving people their medicine. This ensured people received the right medicine at the right time. One person became reluctant to take their medication. The staff member spoke with this person and explained what the medication was for and why it was important to take the medication . As a result the person took their medication. The staff member maintained a clear focus on the person finishing their medication before moving on.

However medicines administered 'as and when required' included protocols providing guidance for staff about when the medication should be used. The guidance included 'a record does have to be made at each medicine round to show the resident has been offered the medication by marking 'C' for carers notes'. The expectation was that staff would then complete the carer's notes section of the MAR to demonstrate that a conversation had taken place with the person and that they had been assessed as requiring the type of medication. The guidance also stated 'When medication is given regularly then a referral to the prescriber should be considered for a review of the resident's medication, as their medical condition may have changed. However, staff we spoke with were unable to describe this process to us. We looked at eight people's MAR's who were receiving medication 'as and when required' regularly. The MAR's did not demonstrate that communication had taken place to ascertain if these people required their 'as and when medication'. We also noted that seven of these people's care records did not demonstrate that a referral to healthcare professional had been considered to assess a change in these people's medical conditions. Therefore the day to day practice of staff was not aligned to the home's policies and procedures in relation

to medication.

We spoke with the registered manager about this and following the inspection they sent us evidence that this had been addressed with staff.

People told us they felt safe. One person we spoke with told us ''They treat me well''. Relatives we spoke with told us that people felt safe. One relative told us ''It's a good place. They are like a family. Otherwise he would not stay there". Another relative told us "He loves it there".

People were supported by staff who could explain how they would recognise and report abuse. Comments included; "I would tell [registered manager] immediately", "I would report it to the senior on duty" and "I would inform my seniors immediately". Staff were also aware they could report externally if needed. One staff member told us "I would come to you (Care Quality Commission)". Another staff member told us "I would go to Oxford safeguarding adult's team".

People's care plans contained risk assessments which included risks associated with; moving and handling, choking, pressure damage, falls, personal care and environment risks. Where risks were identified plans were in place to identify how risks would be managed. For example, one person was at risk falls. This person's care record gave guidance for staff to mitigate the risk to this person by ensuring that the person was supervised by staff whilst they were mobile and for staff to support the person with a wheelchair if they became disorientated or unsteady on their feet. During our inspection we observed staff supervising this person whilst they were mobile.

Another person was assessed as being at high risk of pressure damage. This person's care record gave guidance for staff to mitigate the risk to this person. This guidance included encouraging the person with their daily fluid intake. This person's daily record confirmed that staff were following this guidance. Were people were at risk of pressure damage and falls we saw evidence that the service had worked with physiotherapists and professionals from the care home support service to mitigate that risks associated with peoples care.

We observed, and staffing rotas confirmed, there were enough staff to meet people's needs. Relatives told us there were enough staff to meet people's needs. One relative said, ''There is enough staff around". The registered manager provided a 'dependency tool' that evidenced how the home matched the needs of people against the number of staff needed. During the day we observed staff were not rushed in their duties and had time to chat with people. Throughout the inspection there was a calm atmosphere and staff responded promptly to people who needed support.

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the home. These included employment references and Disclosure and Barring Service checks. These checks identify if prospective staff were of good character and were suitable for their role.

Good

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor the application of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report our findings. 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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

At the previous inspection on 19 October 2015 we found that people's care plans did not always contain information guided by the principles of the Mental Capacity Act 2005 (MCA). This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

At this inspection we found that the home had made improvements to address the areas of concern and bring the service up to the required standards. For example, the service had introduced mental capacity assessments for people who may be deemed as lacking capacity. These capacity assessments included information that was guided by the principles of the MCA in that they included how the service had acted in people's best interests. However some of them lacked detail around what decisions people's capacity was being assessed for.

People were supported by staff who had been trained in the MCA and applied it's principles in their work. All staff we spoke with had a good understanding of the Act. Comments included "The act is to protect vulnerable adults and to assess if people have capacity to make safe decisions at specific times", "We must not assume there is a lack of capacity" and "It's about retaining information and making safe decisions".

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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found the home was meeting the requirements of DoLS. At the time of our inspection the service had made DoLS applications for three people.

At the previous inspection on 19 October 2015 we observed parts of the home where people were living with dementia were not decorated in a way that followed good practice guidance for helping people to be stimulated and orientated. Since our last inspection the service had made changes to the adaption and design of the home to ensure that a stimulating environment was created for the people living there. However, we noted that the service had not made changes to a corridor in the home where music was being played out of a speaker in the ceiling. One visiting health care professional we spoke with commented on the distracting and confusing nature of the location where the music was coming from. They told us "It's not good practice, it is confusing". We spoke with the nominated individual about this and they gave reassurances that they would address this.

On the first day of the inspection we arrived at 08:20 noted that the lounge did not have any heating on due the heating system not working properly This room was full of people, some of whom had blankets over

them. People we spoke with told us they were not warm enough. Comments included "No not really (warm enough)", "The heating's not working, I don't like it" and "I am very cold". We told staff it was very cold in the room and asked what they planned to do about it. Staff then went and got portable heaters and put these in the room to raise the temperature. The service had a written plan that if heating was not working heaters should be placed in the areas to heat the rooms. When we arrive this contingency plan had not been followed. The impact of this was that people had been left to reside in parts of the home that were unacceptably cold. However, we noted that the provider had made efforts to try and resolve the issue. For example, this concern had been recorded within the daily handover record and the service had made contact with heating engineers to try and resolve this.

We noted that the chef had access to information and guidance to ensure that people's dietary needs were being met. For example, there were individual records within the kitchen area that highlighted people's preferences, like and dislikes in relation to food and drink. Records also highlighted dietary needs. For example, records relating to people who required thickeners contained guidance on the consistency in which fluids should be thickened.

Records showed staff had access to training which included; moving and handling, MCA, first aid, safeguarding, dementia, fire awareness, infection control, food and hygiene, pressure care and medication. The service also ran an in house training program matched to a national certificate in care. We noted that a notice board was visible in the home which celebrated staff achievements in completing the national certificate in care. Staff told us and records confirmed that staff had access to further training and development opportunities. Staff comments included "They give me opportunities", "The training is good" and "I am planning to do my NVQ".

Staff told us, and records confirmed they had effective support. Staff received regular supervision (one to one meetings with their manager). Staff told us supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had. Comments included "My last supervision was last month. I get a minimum of one every three months. If I have any doubts or problems they help me out", "We discuss work patterns, what needs doing and they check my ability to understand information" and "We discuss training".

Staff we spoke with told they felt supported by the registered manager. Comments included "It's good here because of the support you get", "They have given me a lot of support since I have been here", "The support is ok, you can arrange a meeting with them it's no problem" and "[registered manager] is very good at supporting me".

People had sufficient to eat and drink. People who needed assistance with eating and drinking were supported appropriately. People were offered a choice of meals three times a day from the menu. During our inspection we observed that the food looked wholesome and appetising. People told us they enjoyed the food provided by the home. One person we spoke with told us, ''They know the job they are doing. The food is fine. We have four meals a day. Breakfast, lunch, tea and dinner". A relative said we spoke with told us, ''The food is fine, if it wasn't she (person) would say".

Menus were displayed in the homes dining area and staff assisted people with their choices. People were offered a choice of drinks throughout the inspection. Where people required special diets, for example, pureed or fortified meals, these were provided by kitchen staff who clearly understood the dietary needs of the people they were catering for.

People had regular access to other healthcare professionals such as, G.P's, occupational therapists and

other professionals from the care home support team. Where healthcare professionals provided advice about people's care this was incorporated into people's care plans and risk assessments. For example, where people had been identified as having swallowing difficulties referrals had been made to Speech and Language Therapy (SALT). Care plans contained details of recommendations made by SALT and we saw staff were following the recommendations.

Good

Is the service caring?

Our findings

People were complimentary about the staff and told us staff were caring. One person we spoke with told us ''They are always around''. Another person told us ''The staff are caring". Relatives told us, "I am very much impressed'', ''Staff are very, very good'', ''They do a wonderful job there" and ''They are loving and caring".

Throughout our visit we saw people were treated in a caring and kind way. The staff were friendly, polite and respectful when providing support to people. Staff took time to speak with people and reassure them, always making sure people were supported effectively and had everything they needed before moving away. For example, one person became disoriented whilst they were walking to the bathroom. Staff recognised this and supported the person to the bathroom. The staff member reassured the person and supervised this person back to where they were sitting in the lounge. The staff member then asked the person if they needed anything before carrying on with their tasks.

People were treated with dignity and respect. Staff took time to ensure people understood what was going to happen and explained what they were doing whenever they supported people. For example, one person was being supported with a task that involved the use of specialist equipment. The staff member explained what the equipment was for and why it was important that the person used it. Throughout this interaction the staff member explained each step of the way.

Staff we spoke with told us the importance of informing people of what was going to happen during care. One staff member said "You ask people how they want us to do something. You don't just do it. It can cause more problems and it's not person centred. It's about people feeling safe".

People told us they were treated with dignity and respect. One person told us "They look after me well, they always make sure I'm covered up". We asked staff how they promoted people's dignity and respect. Staff comments included; "We use towels and cover people", "We always knock on doors before we enter" and "First we must respect people's privacy. Then we must seek permission. Dignity is also about respecting things like which clothes people like to wear".

We saw how staff spoke to people with respect using the person's preferred name. When staff spoke about people to us or amongst themselves they were respectful. People's friends and relatives could visit whenever they wanted to. People were able to meet their relatives in the communal areas or in the privacy of their rooms .
We saw staff call out to people if their room doors were open before they walked in, or knocked on doors that were closed. When they provided personal care, people's doors and curtains were closed. People told us they felt involved in their care. One person told us "We talk about things all the time"

Staff promoted people's independence. Staff we spoke with told us how they supported people to do as much as they could for themselves and recognised the importance of promoting peoples independence. One staff member told us "We encourage people to do what they can do and like to do, It's important we do this daily", "It's important because we are supporting to people to have a normal life" and "We should

support people with their confidence to do what they can". We noted that care records contained a document called 'I can do the following tasks myself'. This highlighted tasks that people still wished to carryout in order to support their independence. For example, washing their face, changing clothes and brushing hair.

Staff understood and respected confidentiality. Records were kept in locked cabinets and only accessible to staff.

Good

Is the service responsive?

Our findings

People we spoke with told us that the service was responsive to their needs. One person we spoke with told us, ''If I need they call the doctor''.

Relatives told us the service was responsive. One relative we spoke with told us, 'The staff know how to intervene. My mum suffers from seizures and last time it was heavier. They immediately called the paramedics and I was called immediately". Another relative told us ''They give me a call if needed''.

A healthcare professional we spoke with told us "They get in touch if there is a problem" and "I feel we have a good level of communication".

People's needs were assessed prior to admission to the service to ensure the service could meet their needs. Care records contained details of people's medical histories, allergies and on-going medical conditions. Care plans had been developed from the information people provided during the assessment process. Care plans were updated regularly to ensure the information was accurate.

We saw evidence that people had been involved in their assessment. Care plans contained 'all about me' documents which detailed the person's history, likes, dislikes and preferences how they liked to spend their time and things that were important to them. For example, we saw that these documents included details on people's favourite foods, where they were born, favourite football teams and family members. One person's care records highlighted an area of the home they liked sitting in. We spoke with this person who told us "I always sit here, I like it".

Staff were responsive to people's changing needs. We noted the service had responded to one person's changing needs surrounding their mobility. Following this change in need the home liaised with the care home support service. The result of this was that the person's mobility improved. The impact of this was that the person's quality of life improved. Guidance in the person's care records highlighted the need to use specialist equipment to support them with their condition. During our inspection we observed staff encouraging this person to use the equipment.

People received personalised care and staff we spoke with were knowledgeable about the people they supported. For example, we spoke with one member of staff who was able to tell us a person's favourite meal and their preferences surrounding personal care. The information shared with us by the staff member matched the information in the person's care records.

People had access to activities which included board games, painting, hairdressing and music therapy. We noted that the service had requested feedback from the professional who had delivered the music therapy. This feedback was positive and demonstrated that people who had attended it had enjoyed it. We also saw evidence that service had arranged a BBQ for people and they went on days out. This included a trip to the local palace. Activities were seen as the remit of all staff. People who decided that they did not wish to participate in activities had this recorded in their records and staff followed this guidance. For example, one

person's care records highlighted '[Person] likes to participate in (activities) however does not wish to participate in (other activities)'. We spoke with this person and they confirmed that staff followed this guidance. A relative we spoke with told us 'She does activities, she is encouraged to but if she doesn't want she won't do any. They respect this''.

People knew how to make a complaint and leaflets asking for feedback about the quality of the service were available in the reception area of the home. One person we spoke with told us ''I don't want to complain, if I have a complaint, I feel they will listen. Everything is straight-forward here.''. Another person told us ''I know the senior carer, I would just tell him''.

The home sought people's views and opinions through satisfaction surveys questionnaire. We observed that the responses to the recent survey were positive.

Requires Improvement

Is the service well-led?

Our findings

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager had not always notified CQC of reportable events. For example, we found seven events that included allegations made by people about staff, concerns raised by other professional surrounding the welfare of people and an incident were a person had been admitted to hospital following a medical condition that had not been reported.

This concern is a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations (2014).

Audits were conducted to monitor the quality of service. Audits covered all aspects of care including, care plans, environmental audits, infection control and medication. However, these audits were not always effective. For example, people's individual medication administration records (MAR) did not always document when staff had assisted people appropriately with their prescribed medicines. We looked at MAR charts for one person who was receiving a medicine to treat a condition that involved their bones becoming brittle and fragile. Staff and care records highlighted that this person was at high risk of falls. This person's MAR charts did not record that this medication had been given. We checked the balance of this person's medication and we were satisfied that this person had received their medicines and that this concern related to record keeping. The medication audit had not identified these gaps.

We noted that two mental capacity assessments did not include information surrounding the specific decision that the person had been assessed as lacking capacity in. We discussed this with the registered manager and they took the appropriate action to ensure that this information was updated in people's mental capacity assessments.

However, an effective quality monitoring system would have identified these concerns and supported the registered manager to continuously improve the service.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were being supported by some staff whose first language was not English. During our inspection we did not observe that this was a barrier for people receiving care. However, to ensure that people had access to the appropriate levels of conversation the provider had put in place educational events with local colleagues to support staff development in this area.

Staff spoke positively about the registered manager. Comments included; [Registered manager] is the best boss I have had", "He knows a lot and he is always updating us" and "I can go to [registered manager] whenever I want, even on a weekend".

The registered manager and the nominated individual told us their visions and values for the home were,

"To have positive relationships with our residents that support their journey", "We want this to be a happy home for people, relatives and staff", "We try our best and we want to be meeting these values".

Accidents and incidents were recorded and investigated. The registered manager used information from the investigations to improve the service. For example, following concerns surrounding the responsibilities of night staff, the registered manager and provider introduced unannounced 'spot checks' to ensure that staff were carryout their responsibilities in line with their job descriptions. We also noted that this had been raised within team meetings along with guidance for staff in relation to the responsibilities of night staff.

Staff understood the whistleblowing policy and procedures. Staff told us they felt confident speaking with management about poor practice. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice. One staff member told us "Of course I would us it. We talk about things like this all the time".

The service worked in partnership with visiting agencies and had links with GPs, the pharmacist, district nurse and Care Home Support Service. One healthcare professional we spoke with told us "We have a good relationship and things are improving here".

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 The registered manager had not always notified CQC of reportable events.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Audits to monitor the quality of service were not always effective.