The Chestnuts Limited

The Chestnuts

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 20 October 2016 and was unannounced. At the last inspection in September 2015, we asked the provider to take action to make improvements to the environment, managing risk for people using the service, staff training, quality assurance systems, notification of reportable events and record keeping. At this inspection we found the provider had followed their action plan and improvements had been made in the required areas.

The Chestnuts is registered to provide accommodation and personal care for up to five people with learning disabilities. There were four men using the service at the time of our inspection. People living in the home have both learning and physical disabilities and some people have limited communication abilities.

There was a registered manager at the service. 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 registered manager had taken action to review records about people's care. Care plans for people accurately reflected their identified needs and the associated risks to their health and welfare. Incidents and accidents had been reviewed or investigated and reported to CQC appropriately.

Since our last inspection essential repairs and redecoration to the environment had been carried out. The home was clean, comfortably furnished and bedrooms were personalised according to people's needs and interests.

We found that systems for managing medicines had been strengthened and the required records were being accurately maintained. Medicines were managed, stored, given to people as prescribed and disposed of safely. There were systems for checking that people received their medicines correctly and that staff administered medicines safely.

The arrangements for staff training had improved. Staff had updated their training where needed and completed training that was specific to people's assessed needs. Staff felt well supported by the registered manager and told us she had made positive changes.

We found the systems to monitor the safety and quality of the service had been strengthened. Further audits and checks had been introduced so the manager knew what was working well and what needed improving in the home.

People were supported by adequate numbers of staff who had been safely recruited. Staff knew how to recognise and report any concerns about people's care and welfare and to protect them from abuse.

People received care which was person centred and responsive to their needs. Risk assessments identified risks associated with individual care needs and staff knew how to manage and minimise risks to people's health and well-being. People's needs were regularly monitored and reviewed. Where needs had changed, staff had taken action to ensure people received the care they needed.

Staff worked well with external health and social care professionals to ensure people received the services they needed. People were supported to keep healthy and their nutritional needs and preferences were met.

People were treated as individuals and staff interacted with people in a caring, supportive manner. Staff understood people's preferences and knew how people wanted to spend their time. People's need for independence and privacy was understood and respected by staff.

People's rights were protected because the provider acted in accordance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. This legislation is intended to ensure people receive the support they need to make their own decisions wherever possible. The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process to make sure that people are only deprived of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them.

Mental capacity assessments had been carried out to determine people's level of capacity to make decisions in their day to day lives and for more complex decisions when needed. Appropriate applications had been made to the supervisory body (local authority) to restrict people's liberty where required.

People were offered choices and staff knew how to communicate effectively with each individual according to their needs. People took part in activities that interested them and were supported to maintain social links and relationships with those close to them.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. We found that action had been taken to improve the environment and cleanliness of the home.

People lived in a clean, hygienic home that was safely maintained. People were protected from the risk of infection because appropriate guidance had been followed.

People felt safe and staff knew how to protect them from the risk of abuse and harm. Staff understood their responsibilities to report any concerns.

There were sufficient numbers of staff to meet people's needs and keep them safe. Appropriate recruitment checks were undertaken to make sure staff were suitable for the role.

Is the service effective?

Good

The service was effective. We found that action had been taken to improve staff skills and knowledge. Staff were provided with training and support that gave them the skills to care for people effectively.

People's rights were protected because staff were aware of their responsibilities under the Mental Capacity Act 2005.

People received the assistance they needed with eating and drinking and the support they needed to maintain good health and wellbeing. External professionals were involved in people's care so that each person's health and social care needs were monitored and met.

Is the service caring?

Good

The service was caring. People were comfortable and relaxed in the company of the staff supporting them.

There were positive relationships between people who lived at the home and staff. Staff knew people well and what was important to them.

People were supported to maintain meaningful relationships

with those close to them.

Staff treated people with dignity, respect and kindness.

Is the service responsive?

Good

The service was responsive. People using the service had personalised care plans and their needs were regularly reviewed to make sure they received the right care and support.

The service was responsive to people's changed needs or circumstances and relevant professionals were involved where needed.

People were involved in activities they liked, both in the home and in the community.

Arrangements were in place for dealing with complaints and responding to people's comments and feedback.

Is the service well-led?

Good

The service was well-led. A registered manager was in post, staff felt supported and there was open communication.

New systems and audits to check the quality of care and safety of the service had been introduced.

Records about people's care were fit for purpose and reflected their identified needs and associated risks.

The Chestnuts

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.

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. Prior to our visit we reviewed the information we held about the service. This included the inspection history and any safeguarding or complaints and notifications that the provider had sent to CQC. Notifications are information about important events which the service is required to tell us about by law.

We carried out this inspection on the 20 October 2016. The inspection was unannounced and carried out by one inspector.

The registered manager was not available on the day of our visit. We spoke with three members of staff which included the shift leader [person in charge] and one of the registered providers. We spoke with one person who used the service. Due to their needs, other people living at the Chestnuts were unable to share their views. We observed the interactions between staff and people and reviewed care records for three people who used the service.

We looked around the premises and checked records for the management of the service including staffing rotas, quality assurance arrangements, meeting minutes and health and safety records. We also reviewed how medicines were managed and the records relating to this.

Following our inspection the deputy manager sent us information we had requested about staff training. We also received written feedback from a professional who had involvement with the service.

Good

Is the service safe?

Our findings

At our last inspection in September 2015 we found the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At that time, people were not always protected from unsafe care or treatment because the registered person had not done all that was reasonably practicable to assess and mitigate identified risks to them. We also found the service did not follow safe practice for the management of people's medicines.

We previously found that records of incidents and accidents involving people using the service had not been consistently completed. We reviewed accident and incident reports for people and noted improvements. Staff had recorded full details about the circumstances of the event and the registered manager had completed an investigation report. This included details of what action had been taken in response, who was informed and whether the incident was reportable to the Care Quality Commission. People's risk assessments and support plans had been updated in response to any incidents which had involved them. For example, risk plans for travelling in a vehicle had been reviewed for one person.

The way medicines were managed had been strengthened and records were completed accurately to show when people had been given their medicines. People had profiles which gave staff information about the medicines prescribed, the dose and reasons for use. The profiles included details of when PRN (as and when required medicine) should be given. These had been updated for accuracy since our last inspection. The medicines administration records (MARs) we checked were fully completed and showed that people had received their medicines as prescribed. We noted one minor error in recording, we discussed this with the shift leader who arranged to contact the GP and arrange for the MAR to be amended.

Appropriate arrangements were in place to order medicines and to dispose of medicines that were no longer needed. There was a system for checking all prescribed medicines and records for the running balance and any remaining stock. Two members of staff carried out weekly checks on medicines to identify and resolve any discrepancies promptly. An audit record was maintained for medicines received into the home and returned to the pharmacy. Staff completed a monthly check to check that medicine administration records corresponded correctly with people's prescriptions.

The registered manager had obtained and shared guidance for managing medicines in care homes issued by the National Institute for Health and Care Excellence (NICE). Staff completed yearly training in the safe administration of medicines. She had also completed observations of staff practice to ensure they remained competent.

Medicines were stored securely in two locked cabinets. During our visit staff received a delivery of medicines and placed them in the second smaller cabinet which was located at floor level. We discussed this with one of the providers who acknowledged that it was not easily accessible and medicines storage could be improved. They told us they would arrange for a larger cabinet to be installed.

At the previous inspection the provider was also in breach of Regulation 15 of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.This was because the premises were not maintained to an appropriate standard and there were insufficient systems in place to ensure the home remained clean and hygienic.

At this inspection we found improvements and people were provided with a clean and comfortable environment. The provider had taken action to refurbish and redecorate areas of the home. People's bedrooms had been redecorated and replacement flooring fitted where needed. Communal areas were free of clutter and damaged furniture had been repaired or replaced in people's bedrooms. The patio door glass panel had been replaced and broken items removed from the garden. New kitchen equipment had been purchased including an oven and dishwasher.

Checks on the home's internal and external environment were undertaken on a monthly basis and systems were in place to report any issues of concern. Any repairs needed were recorded in a maintenance book and there was appropriate documentation for servicing and routine maintenance of utilities such as gas and electrical safety. Fire alarms and equipment were tested to ensure they were in working order. Fire evacuation drills were held regularly involving people using the service and staff. On the ground floor, we found that two uncovered radiators were exceptionally hot and a potential hazard to people who had mobility needs and were at risk of falls. We brought this to the attention of staff and the registered provider who told us they would arrange for immediate maintenance, including fitting replacement radiator covers where necessary.

The home was clean, free from odours and well maintained at the time of our visit. The local authority completed an infection control audit shortly after our last inspection. Staff were provided with refresher training and the service took action to address recommendations from the audit. For example, hand wash dispensers and disposable paper towels were fitted in all toilets and bathrooms. Records were available to evidence that the home was regularly cleaned. Staff completed charts which reflected tasks and duties that needed to be undertaken. Additional cleaning tasks had been completed when necessary.

People who were able to comment said they felt safe. Staff had completed safeguarding training to enable them to recognise and respond to suspicions people may be at risk of harm or abuse. They were clear about their responsibilities and knew how to report any concerns regarding abuse. Information and contact details for the local safeguarding adults team were displayed for easy reference. Policies about protecting people from abuse and whistleblowing provided staff with clear guidance on how to report and manage suspected abuse or raise concerns about poor practice.

Individual care plans contained information about how to keep people safe at home and in the community. Risk assessments detailed risks relating to people's support and how these should be managed in the least restrictive way. Examples included mobility and falls, accessing the local community, and supporting people who may behave in a way that presented risks to themselves or others. Staff demonstrated knowledge and understanding of these risks. They shared examples such as making sure food was prepared correctly for one person at risk of choking and always supporting another person to use the stairs. People's risk plans had been reviewed and updated where needed.

The provider had emergency policies and procedures for unforeseen events such as utility failures or in the event of a fire. People had personal emergency evacuation plans (PEEPs). These included details about the help individuals would need to safely leave the building in the event of a fire or other emergency. Appropriate numbers of staff were trained in first aid and there was an on-call system in the event of emergencies or if staff needed advice and support.

We discussed the recruitment process with a member of staff. They told us they had been asked to provide two references and a police check had been undertaken through the Disclosure and Barring Service (DBS). These checks are used to assist employers to make safer recruitment decisions. We were unable to check staff files on the day of inspection due to the registered manager being unavailable. At our last inspection we found the provider followed safe procedures for the recruitment and selection of staff.

At the time of our inspection there were enough staff available to meet people's needs. There was a stable staff team and the low staff turnover meant that people experienced consistent care and support. Staffing levels included a minimum of two to three staff during the day with one staff member on a sleeping in duty overnight. Staffing rotas confirmed these levels were maintained. People received staff support when they needed it and this was planned flexibly. For example, where there were planned outings or activities, or where people needed one to one support either at home or in the community. Staff felt the levels were appropriate to meet people's needs; they were not rushed and were able to spend time with people.

Good

Is the service effective?

Our findings

At our last inspection we found the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff had not received appropriate levels of training and support to meet people's needs and carry out their role. At this inspection, we found action had been taken to address this.

Staff told us they had attended more training which supported them in their role. They showed knowledge about supporting people's individual needs including autism and epilepsy. Staff training records were not available on the day of inspection due to the registered manager being on leave. Following our visit, the deputy manager provided evidence that staff had attended training courses relevant to the needs of the people they supported. This training had been provided by the local authority and included learning about person centred care, effective communication, behaviour that challenges, record keeping and incident/ accident reporting. We saw that new staff completed a structured induction over a three month period. This focused on people's care and support needs and completion of a checklist to confirm that staff had read and understood important policies and procedures.

Staff received ongoing supervision and appraisal with the registered manager. Appraisals are meetings involving the review of a staff member's performance, goals and objectives over a period of time, usually yearly. Staff told us they felt supported and could discuss any concerns with the manager.

The Mental Capacity Act 2005 (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.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

During our inspection staff always sought people's permission before carrying out any care or support. Staff were aware that decisions about care and treatment needed to be taken in a way that always considered the person's best interests. Daily notes evidenced where consent had been sought and choice had been given. An example showed where a person had declined a medical procedure and staff respected their decision.

People's support plans included a decision making profile, which set out the support people needed. Mental capacity assessments, specific to the decision being made, had been completed. Some staff had completed MCA and DoLS training and there were plans for the few remaining staff to attend a course in the next few

months. Policies and guidance were available to staff and information relating to the principles of MCA and DoLS was displayed in an easy to read format. This helped people living at the home, as well as staff, to understand the legislation.

The registered manager had assessed where a person may be deprived of their liberty and submitted applications as necessary to the supervisory body (local authority). Appropriate DoLS authorisations were in place for some people as it was unsafe for them to access the community unaccompanied.

People were supported to make their own choices about what they wanted to eat and drink. Pictorial signs were available in the kitchen for people to use when deciding and communicating what they wanted to eat. Where people wanted to prepare their own snacks or drinks they were supported to do so. This was confirmed by a person using the service.

Risks associated with any dietary and hydration needs were met. One person had involvement from a speech and language therapist (SALT). Recommendations had been made about the consistency and food preparation required and the practical support they needed. During the evening meal, we saw this person received food and drink in accordance with these recommendations. There was information to ensure meals were prepared safely where another person was at risk of choking. We observed staff cut food into small pieces and checked it had cooled sufficiently before offering it to the person.

People had access to the health care services they needed and their health care needs met by a variety of professionals including the optician, dentist and GP. All appointments with health and social care professionals were recorded and staff had made timely referrals for support when they identified concerns in people's wellbeing. Staff noted any advice given by healthcare professionals and where changes to people's care were required, these were put into place. For example, one person had involvement from physiotherapy in relation to their mobility needs. A staff member confirmed that following assessment, a more suitable walking frame and wheelchair was provided for the person.

People had health action plans that explained what support they required with their healthcare needs. They were in a suitable format and included pictures to help people understand their plan. People also had a hospital passport. This was a document that could be taken to the hospital or medical appointments to make sure that all professionals were aware of people's individual needs.

Good

Is the service caring?

Our findings

People were supported by kind and attentive staff. One person said the staff treated them well and respected their choices and privacy. Some people were unable to communicate verbally with us. We saw they were relaxed and comfortable in the company of staff. Staff were caring, showed patience and took time to respond to people's individual needs. People reacted positively by smiling or vocalising when staff approached and spoke with them. Staff recognised the signs or gestures people used and gave informed choices when providing personal care, preparing meals and planning activities. A professional told us that a person had enjoyed their time at the home and a leaving party was arranged before they moved on from the service.

People's preferences regarding their daily support were clearly recorded. Information was written in a person centred way such as, "what things do you like to do/ what don't you like", "my goals" and "my best weekday." Staff demonstrated good knowledge of what was important to people and how they liked their support to be provided. This included people's preferred routines, how staff supported them with their personal care and the activities they liked to participate in. A staff member described how one person was very resistant to change and reluctant to have their bedroom redecorated. In order to alleviate any anxiety, staff spent time with the person explaining why changes were necessary and also wrote a letter to outline the improvements. As a result of this the person agreed to have their room done while they were away on holiday.

Records evidenced that people were encouraged and supported to make decisions about their care and daily lives as far as possible. There was clear information about how people communicated and how staff should communicate with them. For example, "I use a lot of gestures" and "When happy, I will smile or laugh." An action for staff included, "When it's time to go out, if I don't respond, use a visual aid (my coat) to show me." Another plan explained how to support a person's anxiety and it was important for the person to have space and to avoid a crowded environment.

Where needed, information was made accessible to people. For example, there were easy read leaflets about making complaints and reporting abuse. Care records such as health action plans included photos and plain language to help people understand the information.

Bedrooms reflected each person's individuality, interests, leisure needs and preferences. People had recently been involved in choosing new décor for their rooms and encouraged to personalise them with their own belongings. One person enjoyed music and sensory equipment and their room was furnished to reflect their interests.

Records confirmed that staff supported people to maintain relationships and social links with those close to them. These also showed that relatives and family representatives were invited to yearly review meetings and kept informed about any significant events.

Staff treated people with respect and recognised their choice for privacy. One person told us staff respected

their choice to be alone if they requested it. During our inspection, people chose where they wished to spend their time. We observed staff addressed people respectfully and maintained confidentiality when discussing individuals' care needs. People's personal information was kept private and secure and their records were stored appropriately in the service. In people's files there was a policy outlining their rights when staff accessed their bedroom. Staff had received training on the principles of privacy and dignity and person centred care.

Good

Is the service responsive?

Our findings

People using the service had lived at the Chestnuts for many years. They were supported by an established staff team who understood and responded to their needs. A professional told us the service was able to meet the needs of a person who required an emergency placement in the past. They said, "I have found the staff to be supportive and able to respond to requests."

Needs assessments provided relevant social and healthcare information about people. They reflected a person centred approach to care and explained the support people required for their physical, emotional and social well-being. People's records were personalised with good detail about people's background, interests, hobbies and likes and dislikes.

Each person had a care plan which was individual and based upon the needs assessment. The plans included information on maintaining people's health, their daily routines and the support they needed with personal care. The plans set out what the person's needs were and how they wanted them to be met. They also focussed on what a person could do for themselves and what assistance they required from staff. Where relevant, plans had been developed with input from specialist health and social care professionals. In one example, a physiotherapist had provided guidance and practical advice on how to support a person to safely use stairs. We saw specific guidelines on the support some people needed to manage anxiety and distress and how staff could support them effectively.

People's diverse needs were understood and supported. Care plans included details about people's needs in relation to age, disability, gender, race, religion and belief and sexual orientation. People had the right specialist equipment to promote their independence and meet both their physical and sensory needs. This included mobility aids, picture cards and photographs that considered people's communication needs.

Care reviews had taken place periodically which involved the person using the service, family members and key staff and professionals involved in their care. All aspects of the person's health and social care needs were reviewed at these meetings. Each person had a designated key worker who had responsibility for reviewing people's support plans and personal goals. Support plans and risk assessments had been updated with relevant information where care needs changed. For example, there were details of actions required where one person had experienced weight loss. In another plan, psychology services had made recommendations about the best ways to support a person's specific behaviours and staff had begun to address this.

Staff wrote daily records about each person's daily experiences, activities, health and well-being and any other relevant events such as health and social care appointments. This helped staff to monitor if the planned care and support met people's needs.

People participated in a variety of day to day activities and had recently enjoyed an annual holiday. Care plans recorded what was important to people and how staff should support them with their activities at home and in the local community. Each person had an activity planner which outlined their interests,

hobbies and day to day routines.

Meetings were held for people to share their views and experiences of the service. People were asked about the food and things they would like to do such as social trips and activities. At a recent meeting staff had discussed plans for a holiday with people. One person requested for staff to take them to buy new bedding for their bedroom and this was arranged with their keyworker.

Staff were familiar with people's different communication methods. This meant they understood when a person was indicating how they were feeling and why this might be. One person told us they would speak to their keyworker or staff if they wanted to complain about anything and were confident they would listen. The complaints procedure was displayed within the service and available in an easy read format to help people understand the information. The complaint records showed that the service had received no complaints in the last twelve months.

Good

Is the service well-led?

Our findings

At the last inspection, there was no registered manager and satisfactory steps had not been taken to register one within a reasonable timescale. Since then the manager had successfully registered. The registered manager was supported by a deputy manager who had worked at the Chestnuts for a number of years and knew people well.

At our last inspection we found the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have appropriate systems in place to regularly assess and monitor the quality of service that people received. In addition, people's care and monitoring records were not consistently maintained to accurately reflect the care and support provided.

The registered manager had taken steps to improve quality assurance arrangements and record keeping. For example, new checks were in place that looked at cleanliness and areas of health and safety. Staff carried out monthly audits which looked at the care provided, medicines management, incidents/ accidents, complaints, staff records and the environment.

The registered provider told us they visited the service regularly although they did not write records about these visits. We discussed the inspection approach and fundamental standards set by the Care Quality Commission to check the quality of care of people received. The provider agreed to look at further ways of reporting people's experience of the service. A staff member confirmed there were plans to offer questionnaires to people using the service, their relatives and other stakeholders.

At this inspection, we found that the home's standard of record keeping had improved. People's files had been reviewed and were clearly ordered. They included sections on personal information, needs assessments, care plans, health, medicines, accident and incident records, monitoring charts and daily care notes. Historical or outdated information had been removed. Support plans and risk assessments had been updated six monthly or more often where needs had changed. Guidelines that linked to people's particular needs were recorded. Examples of these included managing behaviour and epilepsy. This meant staff were informed about the actions they had to take to reduce risk and other support measures to ensure people's safety and welfare.

We saw that policies and procedures had been reviewed for accuracy and in line with current legislation. We were unable to view staff files as they were kept secure and only accessible by the registered manager. Information provided after our inspection showed that records about staff training and supervision had been updated.

We previously found the provider was in breach of Regulations 16 and 18 of the Care Quality Commission (Registration) Regulations 2009. This was because they had not notified CQC of relevant events and incidents at the service which they are required to do by law. Before our inspection we checked the records we held about the service. We found that the registered manager had notified us appropriately of any

reportable events. We reviewed information relating to accidents and incidents, this confirmed that appropriate action had been taken and shared with CQC where necessary.

There was an open and inclusive culture in the service. Staff described the registered manager as approachable and supportive. Staff said the registered manager had made positive changes and they all worked well as a team. The staff team were caring and dedicated to meeting the needs of the people using the service. The service promoted and supported people's contact with their families. The registered manager and staff worked closely with health and social care professionals to achieve the best care for people.

Staff meetings were held every two months and included discussions around the care provided and any matters that affected the service, including issues staff wanted to raise. Meetings were also used to share learning and best practice. At one meeting staff discussed safeguarding and what they had learnt from a refresher training course. Minutes of staff meetings were shared and staff used a communication book, shift handover and daily planners to stay informed about any changes to people's well-being or other important events.