Chatting Independently Limited

Chatting Independently Limited - Rectory Drive

Inspection report

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Ratings

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

Overall summary

This inspection was carried out on 9 and 14 November 2014. It was an unannounced inspection and was undertaken by two inspectors. At our previous inspection on 11 April 2013 we found that all of the regulations that we assessed were being met.

Chatting Independently-Rectory Drive is registered to provide accommodation and personal care for up to six people who have physical disabilities. People are accommodated on one floor.

A registered manager was in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff treated people in a way they liked and there were sufficient numbers of staff, although they did not all have the required skills to safely meet people's needs.

People were not protected from abuse because staff were not clear of who to contact if they had concerns about the safety of people.

People's needs were not clearly recorded in their plans of care which meant that t staff did not have the information they needed to provide care in a consistent way. Care plans were not regularly reviewed to ensure that they accurately reflected people's current needs.

Most people spoke positively about the quality of food at the home. However, people were not provided with a diet that met their needs. Appropriate risk assessments were not in place in respect of eating and drinking and this put people at an increased risk of choking. People were not always appropriately supported with their eating and drinking at mealtimes.

The provider's monitoring and audit processes were ineffective and inadequate and had failed to identify issues in the home. Risks to people's health, safety and welfare were not appropriately assessed and managed.

Staff had not been provided with training opportunities to ensure they had all the required skills to carry out their roles.

There was a lack of an effective quality assurance system in place to monitor the service and ensure people received good quality care.

Our concerns about the safety and welfare of people were so great that we immediately informed the local authority of these concerns. As a result of our concerns the commissioners decided to remove all people from this home on 14 November 2014.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff were not aware of the actions to take to ensure that people living in the home were kept safe from harm.

There were sufficient numbers of staff but they did not all have the appropriate skills to keep people safe and meet their assessed needs.

Staff did not have the required training to safely administer people's medicines.

Is the service effective?

Inadequate

The service was not effective.

Staff were not aware of their responsibilities in respect of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People were cared for by staff who had not received appropriate training to provide them with the care that they required.

People's health and nutritional needs were not effectively met as they were not provided with a diet that met their assessed needs.

Is the service caring?

Good

The service was caring.

Staff respected people's privacy and dignity.

Some staff were knowledgeable about people's needs and preferences, especially in regards to their communication.

Most staff spoke with people in a caring and respectful way.

Is the service responsive?

Inadequate

The service was not responsive.

People's care plans did not reflect their current needs. However, people were supported to take part in their choice of activities, hobbies and interests.

People could not be confident that their concerns or complaints would be effectively or fully investigated as there were no policies or recording systems in place.

Is the service well-led?

Inadequate

The service was not well led.

There were a lack of opportunities for people and staff to express their views about the service.

Summary of findings

There were no systems in place to monitor and review the quality of the service provided to people.

A lack of accident and incident records prevented the provider from identifying trends and taking appropriate action.

Chatting Independently Limited - Rectory Drive

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 9 and 14 November 2014 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection, we asked the provider to complete 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. The provider completed and returned the PIR to us and we used this information as part of our inspection planning.

We also looked at other information that we held about the service including notifications. Notifications are information about important events which the provider is required to tell us about by law. We also contacted the local authority safeguarding team for their views on the service.

During the inspection we spoke with three people who used the service, the registered manger, the provider, the deputy manager, four staff and two visiting health professionals. We undertook general observations in communal areas and during mealtimes. We looked at the interaction between staff and the people living at the home.

We looked at two people's care plans and other records related to their care such as medicines administration records. We looked at records relating to the management of the home including staff meeting minutes, service user quality assurance survey questionnaires, staff recruitment files and training records.

Inadequate

Is the service safe?

Our findings

Staff we spoke with were not clear about their responsibilities in relation to safeguarding people from harm. Whilst some staff were knowledgeable in recognising signs of abuse, they were unable to tell us who they would report their concerns to and were unable to find the details of the local authority safeguarding team. Not all staff had received training in safeguarding. This increased the risk of people not being safely supported and protected from the risk of harm.

On the first day of our inspection we spoke with staff about what they should do in the event of an alleged abuse. They told us they would speak to the deputy or the manager. The deputy manager worked across the two of the locations. We found that at the inspection of the other location the previous week the deputy manager in the absence of the manager had not taken the appropriate action following a reported allegation of abuse. This put people at risk of further abuse.

This was a breach of Regulation 11 (1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Medicines were stored safely. Medicine administration records were in place and the recording of medication was accurate. Staff we spoke with told us they had not received any updated training in medication administration although the medication policy stated "members of staff are trained regularly on all aspects of medicines held in the bungalow and the house". However, we found that although none of the staff had received training in how to administer a medication which had been prescribed for use in an emergency situation, they were administering this. Between our two visits to the home, we informed the provider that they must ensure that staff did not administer this medication until they have received the training, and that in the meantime an ambulance should be called if the medical emergency occurred. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at two recruitment records and saw that all staff had been subject to a criminal records check through the Disclosure and Barring Service. However, we also found that both of these records showed that references had been provided from personal friends of staff, that employment histories had not always been checked and references had not always been sought from previous employers. This meant that the required checks to ensure that only suitable staff were employed at the home had not been satisfactorily completed.

This was a breach of Regulation 21(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Risk assessments were not always undertaken to identify risks to people's health. For example, one person was at risk of choking when eating and drinking. Staff were unable to find the risk assessment that provided measures to reduce the risk to the person. Staff confirmed that they had not received training in first aid but they told us from their knowledge they would probably use back slaps if the person choked. This put the person at risk of not receiving safe care.

Another risk assessment which was in place for a person who had a bicycle. This assessment did not contain clear instructions to staff to inform them of the action to be taken to minimise the risks to the person's safety including the use and fitment of a helmet. This put people at an increased risk of harm.

Staffing levels were determined according to the dependency levels of people who used the service and we noted that there were sufficient staff on duty for the people living in the home. We saw that staff responded quickly to people's requests and that staff had time to care for people. Staff told us they felt that on most occasions that there were enough staff on duty.

Inadequate

Is the service effective?

Our findings

During a safeguarding meeting which we attended on 3 October 2014, significant concerns were raised in respect of the safety of people when they were eating and drinking. These concerns were that people's eating and drinking guidelines were not being followed and that people were at a serious risk of choking. Assurances were given by the registered manager that guidelines written by a speech language therapist would be followed. However, when the Local Authorities Safeguarding Lead person returned to the home the following week they found that the guidelines were still not being followed.

During our inspection on 9 November 2014, we also noted that staff were still not following the guidelines provided by the speech and language therapist (SALT). This was in relation to the type and consistency of food that people were to be provided with. This meant that people were at risk of choking. Although we saw that people had enough to eat and drink throughout the day we could not be assured that this was provided to people in a safe way.

Due to the concerns raised in relation to people not receiving the correct type of food and the risk of one person choking, staff from the local authority's Learning Disability Partnership had to attend the home at all mealtimes to ensure that people were receiving suitable food that had been prepared according to the guidelines.

People we spoke with told us that they were able to choose their food and they shopped for this on a weekly basis. Snacks were available between meals for people to help themselves to or they could ask staff for some support to prepare these. Menus were chosen by each person and people were given choices about what they wanted to eat at every meal.

This was a breach of Regulation 14 (1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We received a copy of a letter from the chief fire officer following their inspection of the home on 01 September 2014. This letter raised serious concerns about a number of issues in relation to fire safety. During our inspection we found that the necessary actions had not been taken to ensure that people were protected against the risk in the event of, or associated with, a fire. Personal evacuation plans were not in place for all people living at the home and staff were not aware of the procedure to follow, should there be an emergency in the home which required people to be evacuated. Dangerous substances were not stored securely and combustible materials had not been removed from an escape route. The provider could not tell us why the work required by the fire safety officer had not been undertaken. Appropriate fire safety drills had not taken place for staff to ensure that the emergency plan is rehearsed for its effectiveness. This put people at risk if a fire should occur.

This was a breach of Regulation 15 (1) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us, and we found in records viewed that staff had not received appropriate training, supervisions and appraisals. Staff stated that they felt they were not supported and confirmed that the registered manager only came into the home about once every two weeks to talk to the people living in the home and did not provide them with support.

Senior staff confirmed that there was no induction in place for staff. We found that not all staff had received training in safeguarding people from harm, administration of medication, first aid, fire safety, epilepsy and infection control. The lack of induction, supervision, annual appraisal and support put people at risk of inappropriate or unsafe support.

This was a breach of Regulation 23 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager, deputy manager and other care staff, we spoke with were not fully aware of their responsibilities under the Mental Capacity Act 2005 (MCA) and in relation to the Deprivation of Liberty Safeguards (DoLS). We were informed by the registered manager that there was no one currently living in the home who was being deprived of their liberty. However, there were no formal systems to show how people had been assessed or considered in the planning and delivery of care. In all records we looked at we saw, no one had received a formal assessment to establish their capacity for decision making. We also noted that people's care plans had limited information about how care was to be provided in the person's best interests or their preferences for how their care was to be delivered.

Inadequate

Is the service effective?

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that people had been to visit dentists and opticians to ensure that their visual and oral health was regularly monitored. People were supported by staff to see their GP if they had any concerns with their general health. However, records did not always detail if any follow up action had been taken or that the results from tests had been received and acted upon. For example, one person had recently visited the GP as recorded in the diary but no information about the visit was recorded in the person's file of the outcome or any action that may be required to be taken. This put people at risk of not receiving appropriate care and support.

Good

Is the service caring?

Our findings

One person told us that the staff were lovely and they were supported with their needs. Another person said: “I like living here and I get everything I need”. Another person who had difficulty communicating, but smiled when we asked if they liked living at the home.

People’s dignity was respected. We saw staff quietly speak to one person when they took them to have their personal care needs met. People were taken to their bedrooms to ensure their personal care needs could be met privately. Staff were seen and heard to knock on people’s doors and wait for a response before entering. When entering they introduced themselves and asked if it was alright to come in.

People told us and staff confirmed that families and friends are able to visit at any time, although they told it was best if they rang first to check that people would be at home and they would like to see their visitors.

We observed staff interacting with people who used the service and we saw some positive examples of warm and caring approaches. For example, a member of staff was joking with a person and they responded by laughing and smiling. Most staff talked with the people they were supporting with kindness and warmth. Another member of staff was sat with a person at the table and they were reassuring them about our inspection and was holding their hand and stroking their arm.

People could choose where they spent their time. People told us they were able to choose what time to get up and to go to bed. A member of staff member said: “I love my job it is very satisfying and people get what they ask for, although some need encouragement to take part in their therapies”.

Staff were knowledgeable about what activities people like to do and how they liked to spend their time. People told us that staff spend time talking to them to find out what they would like to do on a daily basis and if they have changed their minds about their choices of activities. People told us that their parents are sometimes involved in the discussions about their care.

Everyone we spoke with had some form of communication aid. Staff were able to explain to us how we could use these when communicating with people. Most staff we spoke with were familiar with people’s expressions and gestures and were able to understand people’s needs.

Inadequate

Is the service responsive?

Our findings

The information contained in two peoples care plans and risk assessments did not reflect their current needs and had not been regularly reviewed. These care plan's had not been reviewed for 10 months despite people's needs changing. Staff confirmed that not all of the care plans were accurate and up to date and that they did not contain sufficient information about how people's needs should be met. This put people of increased risk of not receiving the care as required

We found that where care plans accurately reflected the needs of people they were not always being followed by staff. Staff confirmed and records showed that people were not always receiving their planned therapies due to people not always being ready or the therapist not being available. The lack of care plan reviews and the lack of all the relevant information placed people at risk of receiving care that was inappropriate and/or unsafe.

This was a breach of Regulation 9 (1) (a) (b) (i) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People had various communication aids that they had been assessed to use. These included picture boards and light writers. For one person it was noted in the care plan that they used an electronic computerised tablet to aid their communication; we saw that they did not have this with them. We spoke with a member of staff and they told us they no longer used it but there care plan had not been updated to reflect this.

People living in the home and staff were not aware of the procedure to follow if they had a complaint. People in the home did tell us that if they had a concern they would speak to a member of staff. Staff were unable to find a copy of the complaints policy and were unsure if there was one. The provider informed us that there was no system in place to record complaints received, investigate them or record their outcomes. They were unable to tell us how many complaints or concerns they have received in the last 12 months and they informed us that only complaints received about staff would be recorded and that this information would be in their personnel file rather than on a complaints log.

This was a breach of Regulation 19 (1) (2) (a) (c) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us they were supported by staff to take part in activities of their choice, some of these included going out for lunch, hydrotherapy sessions, visits to the local town and days out to the seaside. People took part in activities that were important to them. People told us that they are able to visit their families with support from staff. Some had been home over the weekend and told us they had enjoyed themselves. We were told by the people who live in the home and by staff that families are able to visit anytime.

Inadequate

Is the service well-led?

Our findings

A registered manager was in post.

Staff told us there were no formal staff meetings, but a handover was held at the start of each shift. This was to ensure information for the day was given and that any issues or people's appointments were discussed.

We found there was not an effective system in place to assess and monitor the quality of the service, or to identify, assess and manage risks relating to the health, safety and welfare of people living in the home. The registered manager stated and we found, that health, safety or medication audits did not take place. This meant that there was no system in place to ensure people received safe care.

We were told by staff that a survey had been conducted in August 2014 to seek the views of people who lived at the home, their relatives and staff. However the provider had not formulated an action plan in response to the analysis of the information received in completed questionnaires.

People told us that the registered manager spent most of their time at the service in their nearby office and only came into the home every couple of weeks. This meant they were not as aware of the day to day culture of the people or the home they lived in as they could have been. Staff felt supported by their peers and they told us that they worked well together. We saw that staff would ask each other for support when needed to ensure people's needs were attended to quickly.

There was a lack of effective systems to identify trends resulting from incidents and safeguarding investigations. For example, the registered manager was unable to inform us about the number and nature of incidents that had happened over the last 12 months because there was no system to bring this information together. The lack of records for accidents and incidents prevented the provider from identifying any potential trends and also taking action when required. This increased the risk of harm to people living at the home.

The registered manager and the provider had not always ensured that notifiable incidents were always reported to the appropriate authorities or that independent investigations were carried out. For example, we noted two safeguarding incidents that had not been reported to the local safeguarding authority and the Care Quality Commission (CQC). We were told that these incidents were being investigated internally which meant information was not shared with agencies involved in the safeguarding of people. The lack of effective reporting mechanisms at the service increased the risk of people suffering harm and that actions to prevent recurrence were not safe or effective.

The registered manager and the provider did not always recognise areas of risk which could result in unsafe care. For example, they had not completed the recommendations following the fire safety officer's report which raised serious concerns and could not give us a clear date when this would be actioned. This meant that the risk of harm to people in the event of a fire was increased.

We also found and saw that the provider's quality monitoring systems had failed to identify that risk assessments did not always identify significant risks to people's health and safety. For example people that were at risk of choking had no risk assessment in place to provide staff with the action to take to minimise the risk.

This was a breach of Regulation 10 (1) (a) (b) 2 (a) (iii) 2 (b) (v) and 2 (c) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **People who used services were not protected against the risks of receiving care and treatment that is inappropriate or unsafe by means of the planning and delivery of care and, where appropriate, treatment in such a way as to meet people's individual needs and ensure their welfare and safety.** Regulation 9(1)(a)(b)(i)(ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **People who used the service were not protected against the risks associated with an ineffective operation of systems to regularly assess and monitor the quality of the services and to identify, assess and manage risks relating to the health, welfare and safety of people and others who may be at risk from the carrying on of the home.** Regulation 10 (1) (a) (b) 2 (a) (iii) 2 (b) (v) and 2 (c) (i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **People who use the service were not protected against the risk of abuse as staff did not respond appropriately to allegations of abuse.** Regulation 11 (1)(b)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People who use services and others were not protected against the risks associated with the unsafe use and management of medicines by means of making appropriate arrangements for the recording and safe administration of medicines.** Regulation 13

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **People were not protected from the risk of adequate nutrition and hydration by means of the provision of a choice of suitable and nutritious food and hydration, and support for the purposes of enabling people to eat and drink for their needs.** Regulation 14(1) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance.** Regulation 15 (1) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The registered person did not have suitable**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	arrangements in place for obtaining and acting in accordance with the consent of people using the service, or establishing, and acting in accordance with, the best interests of people using the service. Regulation 18
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints People who use the service could not assured that any complaints would be acted on investigated and resolved to their satisfaction. Regulation 19(1) (2) (a) (c) (d).
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers People were not protected as the provider had failed to carry out all the required checks prior to a person commencing their employment. Regulation 21(a) and (b)
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place to ensure that staff were appropriately trained to deliver safe care and support to people. Regulation 23 (1)(a)