Care Quality Commission

Voyage 1 Limited

Chiltern View

Inspection report

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Date of inspection visit: 11 June 2015
Date of publication: 21/08/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service responsive?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 20 and 27 January 2015. Breaches of legal requirements were found in relation to maintaining accurate records in respect of each service user and failing to operate an effective recruitment procedure. We also made recommendations around developing a system for checking in medicines in a robust manner and developing a system to ensure staff receive supervisions and annual appraisals in line with the organisations policy and procedure. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches and submitted an action plan informing us they would be compliant by 31 May 2015. We undertook this focused inspection to check that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk

Chiltern View provides accommodation for eight people with a learning disability. At the time of our inspection eight people were using the service.

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

Summary of findings

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.'

At this focused inspection on the 11 June 2015, we found that the provider had made some improvements and had followed most of their plan which they had told us would be completed by May 2015. However there were still some areas of record keeping where improvements could be made. These were in relation to completing monitoring records, specific plans of care for health related conditions and maintaining accurate records to ensure people's health care needs were met appropriately

We saw improvements had been made in relation to the recruitment of staff. The provider had implemented a system for checking agency staffs identification and ensuring a one page profile for each agency worker had been gained from the agency before they began working at the home. This detailed all relevant recruitment checks had been undertaken, checked their eligibility to work, proof of identity any qualifications they held and relevant training they had undertaken. Similarly photographs of staff were now held in their personnel files. This meant a robust recruitment procedure was in place to ensure staff were of good character and had the qualifications and experience to perform tasks in relation to the work they were employed to do.

Further improvements had been made in relation to supporting staff. We found staff were now provided with regular supervision and an appraisal of their work. This meant staff were provided with opportunities to discuss their work and any areas of personal development. We saw these had been documented appropriately within their personnel file.

Systems were now in place to ensure people's routine health appointments were undertaken in a timely manner. Improvements had been made to the recording and monitoring of these to ensure people's health care needs were met appropriately.

Through discussion and observation of staff it was evident they knew the people who lived in the home well. They had built up good relationships with them and were knowledgeable about their individual needs. They were able to communicate with them effectively and were knowledgeable on what particular individual gestures and signs meant. They were able to tell us what they would do in instances in which a person may have a seizure and knew when to escalate such situations to the emergency services.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to the regulations 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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

Some aspects of the service were not safe

The recruitment of staff was now managed safely.

As good practice, further checks were made to the medicines when they were received into the home against people's prescriptions where these were available. This was to ensure they matched those prescribed by people's GP's and correlated with those detailed on people's administration records.

Risk assessments were not in place for an individual to indicate any possible adverse reactions to their treatment and how staff would manage such reactions.

Is the service effective?

Requires improvement

The service was effective

Systems were in place to ensure staff received regular supervision and an appraisal of their work.

We could not improve the rating from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned Comprehensive inspection.

Is the service responsive?

Requires improvement

The service was not always responsive.

Monitoring charts were not completed and guidelines not followed to ensure the provider followed advice and maintained accurate records.

The registered person failed to follow the advice of some healthcare professionals to ensure people's needs were met appropriately.

Chiltern View

Detailed findings

Background to this inspection

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

We undertook an unannounced focused inspection of Chiltern View on 11 June 2015. This inspection was done to check that improvements to meet legal requirements planned by the provider after our visit on 20 and 27 January 2015 had been met. The inspection was

undertaken by two inspectors. The service was inspected against three of the five questions we ask about services: Is the service safe? Is the service effective? Is the service responsive? This is because the service was not meeting some legal requirements.

We reviewed all the information that we held about the service prior to our inspection.

We checked to see what notifications had been received from the provider since their last inspection. Providers are required to inform the CQC of important events which happen within the service. We spoke with the registered manager, operations manager, four support workers and one agency support worker. We reviewed four care and support plans for people who use the service, 3 medication records, recruitment records for a support worker recruited since our last inspection and their supervision records as well as supervision records for two other staff. We also observed a medication round and looked at the provider's medication policy and procedure.

Requires improvement

Is the service safe?

Our findings

At our previous inspection on the 20 and 27 January 2015 we found the provider failed to operate an effective recruitment procedure. They failed to assure themselves that relevant checks had been undertaken for all agency staff and they were suitably skilled and qualified to undertake their role competently and safely. We also found recent photographs were not always held in staff files. This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

During this inspection we found improvements had been made and the recruitment of staff was now managed safely. We observed the personnel file of one support worker who had been recruited since our last inspection and the records of three agency staff who had recently been rostered to work in the home. These records informed us that systems were now in place to ensure all relevant recruitment checks had been undertaken before staff began working in the home. These included satisfactory disclosure and barring checks (DBS), references, employment histories, medical histories and a photograph was held on their files.

The provider had implemented a system for checking agency staffs identification on arrival at the home and ensuring a one page profile for each agency worker had been gained from the agency before they began working at the home. It was the responsibility of the shift leader to check these were in place. We spoke with the shift leader during our visit, who informed us that if a profile had not been gained detailing the relevant training undertaken and the date of expiry, a photograph and confirmation that all relevant checks had been undertaken the agency staff would not work the shift. They told us "we would contact the person on call to cover or our bank staff to cover the shift." They added that the provider tries to avoid having more than one agency staff member on any shift wherever possible. We saw this to be the case during our visit. The home had an agency file in place containing up to date profiles of agency staff who worked in the home.

We also saw documentation which confirmed an appropriate induction to the home was provided to agency workers when placed at Chiltern View. This included an introduction to people living in the home, moving and handling equipment, first aid, record keeping and fire procedures. They were expected to read and understand people's individual support plans, any associated risks and control measures in place so they could provide the support safely. These were signed off and dated and held on file along with their individual profiles. We spoke with one agency staff who confirmed they had been provided with such an induction before they began working with people who lived in the home.

During our last inspection in January 2015 we made a recommendation that the provider developed a system for checking in medicines in a robust manner. This was to ensure the medicines matched those prescribed by people's GP's and correlated with those detailed on people's administration records.

During this inspection the registered manager told us the checking in of people's medicines was the responsibility of the registered manager and the deputy manager. They told us as good practice they had added a further check to the medicines when they were received into the home. This entailed checking the medicines against people's prescriptions wherever possible. However, whilst checking the medicine records for four people we found one area of discrepancy in relation to the number of tablets held in one person's medication cabinet. The registered manager acted promptly to undertake an investigation and spoke with all staff about the discrepancy. Whilst this did not have any detrimental or ill effects to the person this showed the importance of carrying forward any medicines correctly. The remaining three people's medicines were all logged appropriately. However there was some evidence of listing people's medication in too many places. This had the potential for the updating of people's medicines to be missed and therefore not correlate with those on people's medicine administration records.

One person's care plan indicated they had Botox injections for muscle stiffness. There was no risk assessment in place to indicate any possible adverse reactions and how staff would manage such reactions.

Requires improvement

Is the service effective?

Our findings

At our previous inspection on the 20 and 27 January 2015 we found information in one staff member's personnel file which showed they had taken a position in September 2014 and had not received a supervision. We also found another staff member's file showed they had not received an annual appraisal. We therefore made a recommendation that the provider developed a system to ensure staff received regular supervision and an annual appraisal in line with the organisation's policy and procedure.

During this inspection we found improvements had been made. Staff were now provided with regular supervision and an appraisal of their work. We noted a newly recruited member of staff received regular supervisions during their probationary period which had been documented within their personnel file. Likewise we looked at a further two member of staff's files and saw they had been provided with supervision and an appraisal and had been supervised on three occasions whilst administering medication to ensure they were competent before being signed off as competent to undertake such tasks.

Staff we spoke with felt they were well supported and told us the manager had an open door policy where they could meet and discuss any concerns. They further told us they were provided with one to one supervisions, which was a two way discussion to discuss their work and performance. Similarly they received an appraisal of their work where they discussed their work, any concerns and any personal development needs. This meant staff had the opportunity to discuss their work and any areas of personal development with their line manager.

Requires improvement

Is the service responsive?

Our findings

At our previous inspection on the 20 and 27 January 2015 we found the provider failed to ensure people were protected against the risk of unsafe or inappropriate care through maintaining an accurate record in respect of each service user. This was because accurate records had not been maintained in relation to people's routine appointments with dentists, opticians and chiropodists to ensure their health care needs were being met appropriately. Similarly other Information within people's care files was not always up to date and fully completed. For example relationship maps detailing the people who were involved in people's lives and updating people's records in relation to changes in people's emergency medicine in situations where they may have a seizure.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2010, which corresponds to regulation 17(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we saw some improvements had been made. We noted there had been some improvements made to the recording and monitoring of people's routine health appointments. People's individual care and support files contained a document at the front of their file. This was to enable staff to record when they had been for routine appointments such as the dentist, chiropodist, GP or hospital visits. Once staff had recorded the details on the document, notes were made in people's daily notes and any follow up appointments had been diarised. This was to ensure people's health care needs were met appropriately.

We saw people's relationship maps had been completed since our last visit. This provided staff with information about people who were involved in people's lives such as family members and friends.

We noted people's files had been updated to show that their emergency medication had been changed and was taken by a different route. On speaking with staff it was evident they were aware of the change.

However, there were some monitoring records which had not been completed appropriately and one instance in which documentation informed us one person had epilepsy but there was no specific plan of care in relation to their epilepsy to inform staff how this was to be managed.

We saw an instance in which staff were directed to complete a monitoring chart to detail when an individual's continence aids were changed. Their guidance notes within their file stated the individual would be at risk of faecal and urine burns and staff were to maintain accurate records. We looked at the monitoring charts and found gaps where staff had not recorded if they had changed their continence aids. For example on 01 June 2015 we noted the last change had been logged at 3.30pm with no evidence of any further changes throughout the night and the next being at 18.45pm the following day. Similarly on 09 June 2015 we saw records to indicate they had been changed at 02.30am with the next change at 09.00am the following morning. On the day of our visit there was no evidence of any changes having been logged during the day or evening. We were assured the individual did not have any pressure sores or areas of discolouration. This meant staff were not following the guidelines of completing the monitoring charts and maintaining accurate records.

Similarly we noted one person's care plan indicated they had Botox injections for muscle stiffness. They were visited regularly by the physiotherapist who had provided training and instructions to some of the staff team to provide the person with daily passive exercises and to monitor when these had been undertaken. Staff we spoke with were able to describe the exercises they supported the person to complete and the number of movements they were to support them with. They informed us these were undertaken in the afternoon after lunch Monitoring charts were in the individual's bedroom for staff to complete to indicate when they had performed the exercises and the duration. However we noted staff had not been completing the monitoring charts as advised. During the month of March 2015 the monitoring chart had been completed for only 5 days. Similarly in April 2015 the monitoring chart indicated the person had completed their passive exercises for 16 days of the month and in May 2015 only 8 days had been completed. There was no written record to indicate the person had chosen not to undertake the exercises. This meant staff were not following the advice of the healthcare professional and maintaining accurate records to ensure the person's health care needs were met.

Requires improvement

Is the service responsive?

These were continued breaches of regulation 17(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted one person's records indicated they had epilepsy and there was no specific plan of care in place to inform staff how this was managed. In discussion with the registered manager and staff it was apparent the individual had absence epilepsy which did not require medication. Staff were aware of how they were to support the individual if they had such a seizure. The registered manager informed us that whilst there was no action to take during these seizures other than reassurance this would be added to their care and support plan. We noted an on going emergency management plan dated 09 December 2012 was held in their file which informed staff when the GP should be consulted and when staff should call the emergency services.

The registered manager informed us that it had been their intention to source some record keeping training for staff to attend. However we were informed they had been unsuccessful in accessing any training locally although the registered manager had covered record keeping during staff supervision. Through discussions with staff it was evident they knew what they were to record, when and how including any changes to s care and support needs. We also saw supervision records to verify the registered manager had discussed record keeping with staff.

We spoke with two staff who were knowledgeable about people's individuals needs in relation to their epilepsy and were able to tell us what they would do in any instances in which they may have seizures. This meant that whilst specific plans of care were not available the staff would act appropriately in such instances. We also spoke with an agency staff who was knowledgeable on their needs and knew what to do if they presented with a seizure.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who use services and others were not protected against the risk of unsafe or inappropriate care through maintaining an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

The enforcement action we took:
We served the provider a warning notice due to a breach of regulation 17. We asked the provider to take appropriate action by 17 August 2015