SR Care Limited

The Chestnuts

Inspection report

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Ratings

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

Overall summary

An unannounced inspection took place on 19 March 2015. Our previous inspection of 19 February 2014 found the provider was not meeting one regulation at that time. This was in relation to care and welfare of people who used the service. Following that inspection the provider sent us an action plan to tell us the improvements they were going to make. Although action had been taken to improve we identified additional breaches in relation to safeguarding, risk assessing, assessing and monitoring the quality of service provision and notification of incidents.

The Chestnuts provides care and support for up to 14 people with learning disabilities with a range of support needs. The service is situated in Coalville and is a converted two floor property with a number of communal areas and garden available for people to use. There were seven people using the service at the time of our inspection.

There was no registered manager in post at the home. 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'.

Summary of findings

Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. A new manager had been recruited and was in post for a matter of weeks at the time of our inspection. They intend to apply for registered manager status but an application had not been received at the time of writing this report. The home had had a number of different managers in a relatively short space of time.

People using the service were complimentary about the staff team and satisfied with the care and support they received. People's independence had been promoted and people's privacy was respected. We found that people had been asked for their consent and staff had acted in accordance with their wishes. Some people told us they had not felt safe living at The Chestnuts. This was because of the behaviour other residents had exhibited. People were able to spend their time as they chose but encouragement and support to engage in meaningful occupations was lacking.

People had not been protected from abuse or the risk of abuse because the service had not always informed the appropriate authorities of incidents where people had been harmed by other people's behaviour. Incidents and accidents had been recorded but these had not been analysed to prevent future occurrences. Risk assessments and care plans provided insufficient guidance for staff about how to manage and respond to such behaviours and staff were often inconsistent or inappropriate in their responses. This exacerbated the problems and risks that people experienced.

Staff had received training and felt supported by the new manager but we were concerned about their ability to manage challenging behaviour effectively. Wehave made a recommendation about staff training in positive behaviour support.

Risk assessments and care plans had been reviewed and updated but care was not always provided in accordance with these. This had placed them and others at risk. Medicines were stored and handled appropriately by trained staff but medicines that were given 'as required' had not been managed safely. There was one occasion where someone had not received their prescribed medicine and appropriate action had not been taken.

Support to access healthcare services had been provided and people were able to make their own choices about eating and drinking. However, staff had not always promoted a nutritious, balanced diet.

People's likes, dislikes, preferences and individual needs had been recorded by the service and we found staff encouraged people to make their own decisions and respected their choices on a day to day basis. Staff supported people in a calm and professional manner and had developed positive relationships with people living at the home. They respected people's privacy.

Staff recruitment procedures were robust and ensured that appropriate checks were carried out before staff started work. There were sufficient numbers of staff available to meet the needs of the people who lived there.

Systems were in place to gather the views of people living at the home but action was not always taken as a result. There was a complaints procedure in place but it had not always been used appropriately.

There were systems in place to assess and monitor the quality of the service but these were ineffective. They had not identified shortfalls in service provision or foreseeable risks to people's health and welfare or provided the information that the provider needed to ensure that people were safe or improve the service. This had placed people at risk of receiving inappropriate or unsafe care.

The requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2008 were known and understood by the new manager.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which correspond to breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we took at the back 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?

Inadequate

The service was not safe.

People had not always felt safe. They had not been protected from the risk of abuse as incidents of challenging behaviour between the people who lived there had not been referred to the appropriate authorities. There were shortfalls in people's risk assessments and inconsistencies in how staff responded to people's behavioural difficulties which had placed them and others at risk.

Medicines were not always managed safely. The home had been maintained but not all required maintenance had been carried out.

Staff had been properly recruited and there were sufficient numbers to meet the needs of the people who lived there.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had been trained and felt supported by the provider however they had not received adequate support and training to enable them to respond to people's behavioural needs effectively.

People's independence with regard to eating and drinking was promoted but people had not been supported or encouraged to eat a balanced diet. People had been supported to access healthcare services whenever required.

Consent to care and support had been sought and staff acted in accordance with people's wishes. Principles of the Mental Capacity Act 2005 were known and understood.

Is the service caring?

Good

The service was caring.

People's privacy was respected at the service. Staff treated people with kindness and respect and encouraged them to maintain their independence.

People were able to express their views about their care and support needs and staff respected their wishes.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had severely limited opportunities to be meaningfully occupied. and had not been supported or encouraged to take part in social, educational or work opportunities they may have benefitted from and met their needs.

Summary of findings

People made decisions about their care and support but their views had not always been taken into account in the way the service was run.

There was a complaints procedure in place but complaints and concerns had not always been responded to.

Is the service well-led?

Requires Improvement 

The service had not been well-led.

There were systems in place to monitor the quality of care at the service but these had failed to identify shortfalls in a number of areas and could not be used by the provider to support improvements that were needed. There insufficient learning from incidents. CQC had not been notified of relevant events as required by law.

There had been numerous management changes and no registered manager in place. A new manager had recently been appointed and staff had confidence in them. Staff were positive about their role and committed to making improvements.

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 we reviewed the information we held about the service along with notifications that we had received from the provider. A notification is information about important events which the service is required to send us by law. Prior to our inspection we contacted the local authority and took the information they provided into account as part of our planning for the inspection.

This inspection took place on 19 March 2015 and was unannounced. The inspection was carried out by two inspectors.

We spoke with five people who used the service, the new manager and four members of staff. We also reviewed a range of records about people's care and how the home was managed. This included three people's plans of care, four staff records, medication records and records in relation to the management of the service such as audits, checks, policies and procedures.

Inadequate

Is the service safe?

Our findings

Some people we spoke with told us that, at times they had not felt safe living at the home. Three people told us this was because of the behaviour of another person who lived at the home. This person was not present during our inspection. One person told us they wanted to live inside an 'electric fence' so they'd be protected. They told us about an incident where this person had thrown a metal kitchen utensil which had hit them on the head. They said this had caused a bump and graze. Staff also recalled this incident.

Another person told us, "I'm safe here but it's sometimes difficult with [the other person] targeting us". A third person explained how they would stay in their room and avoid this person because they would 'shout' and described their intimidating behaviour to us.

We spoke with the staff team about these issues and were told there had been lots of incidents of challenging behaviour, particularly between people living at the home, some of which involved incidents of physical violence. One staff member told us, "Some days there's loads of them".

We looked at completed incident and accident charts and found numerous records of people living at the home being, hit, kicked, shouted at and having their hair pulled by other residents of the home. There were also incidents, such as that involving the metal kitchen utensil above, which had not been recorded. The provider had failed to identify many of these incidents as safeguarding matters and these incidents had not been reported to the local authority or to CQC as required. This meant that the provider had not taken all reasonable appropriate steps to identify incidents of possible abuse or to respond to such incidents appropriately. They had failed to protect people using the service from abuse.

We looked at the provider's policy and found that it was not in line with national and local guidance about how to protect people from the risk of abuse. This was because the policy instructed staff to investigate the issues themselves rather than referring to the local authority. The local authority is the lead body responsible for the investigation of safeguarding issues and should be immediately informed if vulnerable adults have been placed at risk of, or experienced abuse.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the new manager about this. They were aware of local processes for reporting allegations of abuse and understood that behavioural incidents between people using the service would meet the criteria for a referral. Following our inspection we made a safeguarding referral to the local authority regarding specific incidents within the home.

Our previous inspection of 19 February 2014 found people's care and treatment was not always appropriately assessed, planned or delivered to meet their individual needs, safety and welfare. The provider sent us an action plan to tell us about the improvements they were making. We looked at people's care records and found they included individual risk assessments which identified potential risks to people's health or welfare. Risk assessments recorded these risks and any action that should be taken to minimise the risk. We also found that people's plans of their care had been reviewed and up dated. However, we found that staff were not always following the guidance given in people's risk assessments and plans. For example, one person's risk assessment recorded they were at risk of choking and stated that staff should observe discretely whilst they were eating so that they could intervene swiftly if necessary. However, on the day of our inspection we observed this person eating their lunch without any observations or checks from the staff team on duty. This person's choking risk had not been mitigated in any other way. This meant that staff were not following the guidance in place and placed this person at risk.

We also found that people's risk assessments and care plans in relation to their behaviours were inadequate. Although people's records were clear about the behaviours they presented with and signs of anxiety they may display, there was no guidance for staff to follow so people's behavioural challenges could be dealt with safely. We spoke with staff who told us about the different strategies they used when supporting people whilst they were anxious and found inconsistencies in their responses. For example, one staff member said us they told the person they wouldn't speak with them for two minutes whereas another staff member told us they asked the person to go

to their room. The responses to people reported to us by staff and at times recorded on the incident and accident forms we looked at were also inconsistent. One incident form referred to a person being placed on a 'time out' and another said 'told them it wasn't nice'. People were at risk of receiving unsafe or inappropriate care because staff were not following risk assessments or plans. Shortfalls in the assessment of the risks people's behaviour presented and shortfalls in the planning and delivery of people's care also meant that people were exposed to foreseeable and unnecessary risks to their health and welfare.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with were satisfied their medicines were being handled safely by staff at the home. One person said, "I get my medicines and they've explained what they're for". Another person told us they self-medicated and kept their medicines in their bedroom. We found that the staff team had risk assessed this and had a monitoring system in place.

Medicines were being stored correctly and were administered by staff who had received training in the safe administration of medicines. Controlled drugs were being stored and managed appropriately in line with national guidance. Most people's medicines had been administered as prescribed. However, we found one person's medicine for anxiety had not been administered on one day. We spoke with staff member about this and they told us the staff member thought it was out of stock but it was not. No action had been taken to report this or speak with the person's GP.

There were a number of medicines prescribed to people as PRN. This is medication that is given when required. There were no protocols or any other guidance in place to advise staff about the circumstances under which they should be administered. This placed people at risk of receiving their PRN medicines inappropriately. On one occasion we found that PRN had been administered to a person but the dosage, time and reason for this had not been recorded.

The home had a system in place for monitoring medicines to ensure they were being managed safely. This included a series of checks and audits. However, this had been carried out inconsistently and had not identified shortfalls. People's medicines were not being managed safely.

The home had been maintained to ensure it was safe for the people who lived there. Health and safety audits had been carried out and maintenance issues recorded in a book. However, it was sometimes unclear whether the issues identified had been resolved. For example, a check of the fire doors recorded they were not closing properly and we could not see evidence that these had been mended although other fire safety checks had been carried out. We spoke with the manager about this and they agreed to check the fire doors and other unresolved maintenance issues.

We looked at staff records and found that appropriate checks were undertaken before staff began working at the home. This meant people using the service could be confident that staff had been screened as to their suitability to care for the people who lived there. People we spoke with told us staff were always available whenever they required support. Our observations confirmed there were sufficient numbers of staff on duty to meet the needs of people who lived there.

Requires Improvement

Is the service effective?

Our findings

People we spoke with all satisfied with the staff team and the care and support they provided. One person told us, "The staff are very nice". Staff we spoke with felt supported by the provider and manager and told us they had received sufficient training to enable them to provide appropriate support. One staff member told us they had received a thorough induction and training which had included a period of observing other more experienced staff. Records we looked at confirmed staff had received training in a number of areas that were relevant to their role. Staff had also been supported through the use of meetings and supervisions. The new manager had held supervisions with the majority of the staff team since they had been in post and staff were confident that the new manager would be supportive.

However, we were concerned about the support staff had received when responding to and dealing with behavioural challenges from people who lived at the home. Staff told us they had received 'intervention training' but we identified that staff were inconsistent and at times inappropriate in their approaches to the management of people's challenging behaviour.

We recommend the service finds out more about training for staff on positive behaviour support based on current best practice and in relation to people with learning disabilities.

We looked at the support people required in relation to their eating a drinking. Any risks people had in this area had been noted within their care plans and their likes, dislikes and personal preferences had been recorded. Most people were independent and told us they chose what they ate and some even prepared and cooked their own meals within kitchenettes in their bedrooms. Most people ate their meals with the other people living at the home and we were told they took it in turns to choose the meal. People were supported to be as independent as possible when preparing meals and the staff team were flexible with the support they provided.

However, we noted that most of the chosen meals on the menu plan were highly processed. For example, the meal chosen on the day of our visit was frozen pizza, oven chips and coleslaw. We also found a lack of fresh fruit and vegetables at the home with most of the food stock being processed. Although people had made choices about the food they wanted to eat, staff had not considered whether people were eating a nutritionally balanced diet or promoted healthy eating. One person's records showed they had put on over 12kg of weight in 8 months and 25kg since they had moved to the home under two years ago. Staff told us this was because of the number of snacks the person was buying and consuming but there had been no action taken to speak with the person about this. The provider was not sufficiently attending to their responsibilities to protect people from the risks associated with inappropriate diet. We spoke with the manager about this and they agreed that 'healthy eating' had not been promoted within the home.

People told us about the support they received with regard to accessing healthcare services. Some people told us they went to their appointments independently whereas others told us staff would take them when required. One person said, "They take me to see my psychiatrist and know it's important I go". Records we looked at confirmed that people's health had been monitored by the home and that people had seen relevant health professionals such as dentists, doctors and community nurses when required.

People we spoke with were confident that staff asked for their consent to care and support and told us staff always acted in accordance with their wishes. One person told us, "The staff are here to help. They speak with me about my support but I make my own decisions". Another person said, "Staff support me with my finances but there's other things I do by myself". Throughout our visit we found staff asked people what support or help they required and respected their wishes.

The new manager had a good understanding of the requirements the Mental Capacity Act (MCA). The MCA is a law providing a system of assessment and decision making to protect people who do not have capacity to give consent themselves. Staff we spoke with were aware of the MCA and had some understanding of the requirements. Records we looked at showed that the service had considered people's capacity to make different decisions about their care or support but the MCA had not been required as people had capacity to give their consent. Records showed that people's consent had been sought and the decisions they had made were respected.

There was nobody deprived of their liberty at the time of our inspection. The Deprivation of Liberty Safeguards

Requires Improvement

Is the service effective?

(DoLS) are a law that requires assessment and authorisation if a person lacks mental capacity and needs to have their freedom restricted to keep them safe. The manager had a good understanding of the DoLS, including the circumstances which may require them to seek a DoLS authorisation.

Good

Is the service caring?

Our findings

All people we spoke with told us staff were kind, friendly and treated them with respect. One person said, “It’s a really nice home to live in” and another told us, “The staff are all excellent”.

People told us that staff provided them with the level of support and care they required and that this was always in accordance with their wishes. People felt that staff listened to them and offered to help them whenever this was required. One person explained about the support staff had given them with learning about how to manage their finances independently. They valued the time staff had taken to support them with this and told us, “They’re always here to help us”.

During our visit we observed staff were polite and kind to people living at the home. Staff were patient and took the time to answer people’s queries or explain things to them. They respected people’s wishes and involved them in the day to day tasks that were taking place in the home. Staff demonstrated a genuine rapport with the people who lived at the home and were calm and caring in their interactions.

People we spoke with told us they were able to make decisions about their care and support. For example, they were able to move freely about the home and many told us they went out independently to visit family or to the local town for example. Records showed that people’s individual needs, wishes and preferences had been sought and recorded. People had regular reviews of their care plans but it was not always clear how they had been involved in this. Some people told us they had not seen their care plan before and would have liked to, whereas others told us they were not interested in seeing their care plan. However, all people we spoke with told us they had a key worker and they were able to speak with them about their care or support.

Most people were able to speak about their needs independently and people’s families or other relevant individuals had been involved whenever it was appropriate. One person had no involved relatives or representatives and we found the service had provided them with advice and guidance about advocacy services which demonstrated they had sought to support the person to express their views.

Staff we spoke with gave us appropriate examples of how they maintained people’s privacy and dignity, for example by providing care or support discretely. People told us staff always knocked on their bedroom door before entering and respected their privacy. Our observations confirmed this. People’s bedrooms contained their personal possessions and we were told that people were able to choose how they had their rooms decorated.

Requires Improvement

Is the service responsive?

Our findings

We looked at how people spent their time at the service during our inspection and found that there were very few formal arrangements, structured activities, events or opportunities provided for people to develop their skills. Some people were able to go out independently and chose what they were doing on a day to day basis. This included visiting the local town and family and one person attended a work placement that had been arranged by their social worker. However, many people living at the home had little to occupy their time. On the day of our inspection a staff member took two people to the local shop to buy their lunch and this was the only activity or event that took place.

We spoke with people who used the service about how they spent their time. People who could go out independently told us about the things they were doing. Some people told us about their interests and hobbies and described the sort of activities they would like to do but were not. One person described the home as a "bit boring". They went on to say, "I don't want to make a complaint but I would like to do more". Another person told us about a work placement opportunity they used to have. They told us they would have liked to so something similar and also told us about a course at the library they used to do and enjoyed. We spoke with staff about this and they told us these opportunities had come to an end but nothing further had been put in place.

Staff also told us they decided on the day what they were going to do and asked people for ideas. We were told they sometimes 'went out for lunch'. Another staff member told us they took someone swimming and we also were told there had been a Christmas party. However, more generally people had not been supported or encouraged to follow their interests or take part in social, work or educational opportunities.

We spoke with the manager about this and they told us they had also found many people lacked any formal arrangements to occupy them on a day to day basis. They explained staff had tried to arrange visits and trips but people did not want to go out when the time came. However, they acknowledged that improvements should be made in this area.

We looked at people's care plans during our inspection and found that these contained information about people's health and support needs. We saw that these plans and risk assessments were regularly reviewed and updated but did not always contain sufficient guidance for staff about how they should meet people's needs, particularly in relation to their behaviour. Care plans contained information about people's views, preferences and likes and dislikes but it was not always clear how people were involved in the development of these plans. However, we observed that people were consulted with on a daily basis about their care and support and encouraged to make their own decisions and maintain their independence whenever possible.

People were able to express their views about the service but it was not always clear about how these were gathered and responded to. We found that residents meetings had happened but these were sporadic and any actions taken as a direct result of the meetings were not recorded. People had also been provided with a questionnaire which asked them for their views about the service and the care they received. Although these had been completed they had not been collated in any way and so it was difficult to see how people's views could be used to improve the service.

People using the service told us they would be happy to raise a complaint or concern with the manager or staff team and were confident they would be listened to. There was an appropriate complaints policy in place and a system in place for dealing with complaints received. We looked at the complaints log and found there had been no complaints recorded by the home within the last 12 months. We were aware of a complaint made by a family member but the provider could not give an account of how this had been responded to. In other records we looked at, we found reference to a person raising a concern about another person who lived at the home 'picking on them'. This had not been recorded as a complaint and we could not see how it had been addressed by the previous manager. This meant that people's complaints or concerns may not have been appropriately identified as complaints and then responded to.

Requires Improvement

Is the service well-led?

Our findings

The service had not notified CQC of all incidents it was required to by law. This included a number of incidents when people using the service had been caused harm by other people living at the home. **This was a breach of Regulation 18 of the CQC (Registration) Regulations 2009 Notification of other incidents.**

During our inspection we identified a number of concerns and shortfalls. These included concerns in relation to safeguarding, risk assessing, management of medicines and staff training. We also found that incidents of challenging behaviour had not been managed appropriately at the home. Although incident and accident forms had been completed there had been no consistent management oversight, and they had not been used to improve the service or protect people. For example, no monitoring for patterns and potential causes of these was undertaken in order to reduce the risk of similar incidents from occurring again.

There were systems in place to assess and monitor the quality of service provision at the home which had included the use of audits and checks. However, these had failed to identify and respond to the concerns that we identified during our inspection. This meant that people had not been protected from the risk of inappropriate or unsafe care because of the failure in the management systems. We also found the home had had several changes in management which meant that there was no consistent oversight with what was happening at the service which might have in itself identified and responded appropriately.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with were positive about their role and working at the home. They did however acknowledge the difficulties that had been caused by changes in management at the home. One staff member told us, “It’s been a bit stressful and had got slack”. They went on to tell us they had confidence in the new manager saying, “she’s already boosted us up with all the changes”. Another staff member told us, “There’s been loads of managers’ – a lack of clear direction. [The new manager] has set clear expectations”. All staff we spoke with were positive about how the service could be developed and improved and had confidence in the new manager.

The home had been without a registered manager since December 2014. An interim manager was then in place but they did not make an application to become the registered manager of the home. A new manager had been appointed and came into post a couple of weeks prior to our inspection. We spoke with the new manager and the provider’s representative and were told they intended to make an application for registered manager status. However, this had not been submitted at the time of writing this report.

We discussed our findings with the new manager and found they had identified areas in which the home could improve. They had already initiated improvements to the cleanliness of the home for example. However, they needed further time to make the necessary improvements the home required and to embed these into practice

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: Systems had not been operated effectively to protect people from abuse and improper treatment. Regulation 13 (1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment Risks to people's health and safety had not been adequately assessed and action had not been taken to mitigate such risks. Regulation 12 (1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: Systems designed to protect people from inappropriate or unsafe care were ineffective and poorly managed. Regulation 17-(1)(2)(a)(b)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care

Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

Regulation 18 of the CQC (Registration) Regulations 2009 Notification of other incidents.

How the regulation was not being met: CQC had not been notified of relevant incidents about abuse or allegations of abuse involving people using the service. Regulation 18(2)(e)