Cygnet Learning Disabilities Midlands Limited

Chaseways

Inspection report

1 Chaseways
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16 January 2020
27 January 2020
18 February 2020

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Chaseways is a residential care home providing personal and nursing care to 4 people aged 65 and under at the time of the inspection. The service can support up to 6 people who require daily support with their learning disabilities and / or mental health needs. The building has been adapted so people can live within their own self-contained accommodation.

The service has not been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service did not receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

People's experience of using this service and what we found

People were not supported by sufficient numbers of staff. Risks to people's safety and wellbeing were identified, but not reviewed when their needs changed. Staff had unnecessarily restricted people's freedom through use of restraint without following best practices guidance. People were not protected from the risk of harm or abuse as incidents were not investigated.

Staff did not receive training to enable them to fully support people's needs. Staff did not feel supported by the interim manager. People's nutritional needs were not consistently well met.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The service didn't always apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence. The outcomes for people did not fully reflect the principles and values of Registering the Right Support as people had a lack of choice and control, limited independence and limited inclusion in the community.

Governance and oversight of the service did not identify areas of improvement. Management arrangements in the service were not sufficient to keep people safe from harm. The interim manager and provider did not act in an open and transparent manner when things went wrong. People were not effectively engaged with by the management of the service.

People were safely supported with their medicines. People lived in a clean environment. People were able to

see health professionals when needed and staff supported them to attend these appointments. The environment was adapted to meet people's needs, however some areas required ongoing maintenance or decoration.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 07 November 2018).

Why we inspected

The inspection was prompted due to concerns received about inappropriate use of restraint along with people at risk of harm from lack of staffing, effective training, lack of management oversight and people's nutritional needs being unsupported. A decision was made for us to inspect and examine those risks.

As a result, we undertook a focused inspection to review the Key Questions of Safe, Effective and Well-led only.

We have found evidence that the provider needs to make improvements. Please see all sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

We found evidence during this inspection that people were at risk of harm from this concern. We reported these concerns to the provider who took immediate action to make improvements and promote people's safety. We also informed the local authority of our concerns. We found the actions taken by the provider had been effective in mitigating the urgent risks, however, also found further improvements were required.

On 15 February 2020 we received further information that suggested staff were not supported to raise their concerns and that staff were not being supported. We found no further evidence at that time to substantiate the concerns received on this occasion. Please see the 'Effective' section of this report.

Enforcement
We have identified breaches in relation to safe care and treatment, staffing, safeguarding service users from abuse and improper treatment, meeting nutritional needs, training and support for staff, good governance, and being open when things go wrong at this inspection.

The service is rated as inadequate overall and in the Effective and Well-Led key questions.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Chaseways on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner. We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service has been placed in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration,

we will re-inspect within 6 months to check for significant improvements.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective finings below.	**Requires Improvement**
Is the service well-led? The service was not well led. Details are in our well led findings below.	**Inadequate**

Chaseways

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by one inspector

Service and service type
Chaseways is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means that the the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The previous registered manager left on 16/10/2019. The regional manager provided interim management of the service. A new manager started on 06 January 2020. They had not submitted an application to register as the manager. As there was no registered manager the report will refer to the new manager as 'Manager.'

Notice of inspection
This inspection was unannounced.

What we did before the inspection

The provider completed the required Provider Information Return. This is information providers are required to send us with key information about the service, what it does well and improvements they plan to make. We raised our concerns with the provider on 09 January 2020 regarding the concerns raised to CQC. The provider visited the service on 09 January 2020 to follow up the concerns raised and provided us with an immediate action plan. We reviewed information we had received about the service since the last

inspection. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan and inform our inspection.

During the inspection
We visited the service on 10 January 2020. We returned on 16 January 2020 to ensure required actions were completed. Between 16 January 2020 and 24 January 2020, we sought further information from the provider and spoke with the local authority and staff. We spoke with two people who used the service about their experience of the care provided. We spoke with eight members of staff including support workers, the provider, operations director, regional / interim manager, and manager.

We reviewed a range of records. This included two people's care records and medication records. We looked at staff files in relation to recruitment and staff development. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We sought assurances from the provider around supporting people safely, appropriate use of restrictive practice, provision of sufficient food and clothing, and review of systems and processes to keep people safe. We spoke with the provider and two staff members to validate evidence found. We spoke with the local authority commissioning and safeguarding teams to raise our concerns.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- Systems and processes in place to protect people from the risk of harm or abuse were not used effectively or monitored. People had frequently displayed behaviours that challenged. Staff recorded the incidents and reported to the regional manager. However, we found numerous incidents had not been responded to.
- One staff member when using restraint had caused bruising to a person. This had been documented by staff and reported to the regional manager, however no action was taken. Ten days elapsed before the regional manager took action to review the incident and report the use of unnecessary force to the local authority. Further incidents had not been reviewed by the regional manager, leaving people at risk of harm.
- Staff were not kept informed of incidents within the service, or the outcomes from these. Lessons learned were not shared with the staff team so they could review their practice. The regional manager told us that incidents, trends or patterns were reviewed at monthly operational meetings. However, when we reviewed the minutes from these meetings, incidents relating to Chaseways had not been discussed.
- We asked the regional manager how they monitored trends emerging. They told us, "I'll be honest with you that we haven't done this, I have shown [Manager] how I want them to be working." The provider had not ensured that serious incidents were reviewed, leading to improvements in the support provided for people.

Systems were in place but not operated effectively to keep people safe from harm or abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

- The provider and new manager following our feedback on the first day reviewed incidents within the home, and the use of restraint. No further uses of physical restriction were used when we visited on the second day. When we reviewed concerns raised on 15 February 2020, this remained the same.
- Systems were put in place to monitor incidents and learn lessons among the staff team.

Assessing risk, safety monitoring and management

- The regional manager whilst managing the service had not always ensured that the use of restraint had been safe and effective. Some records showed that restraint had not been the least restrictive option and used for the shortest amount of time. We found that low level restraint such as arm holds or seated holds had been used inappropriately when staff supported people.
- Documents showed that staff had restrained people when they had not explored techniques described in care records to ensure that they did so safely.
- People's risk assessments had not always been reviewed following an incident. The safe and effective use

of restraint had not always been reviewed after physical interventions had been used. There was inadequate debriefing and learning from incidents; even when staff members told us that they had raised safety concerns about the management of the incident.

The risks to people's safety and welfare had not been sufficiently assessed or reviewed when their needs changed. Support to people when displaying behaviours that challenged did not follow the guidance in their care plan. This was a breach of regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

● In response to our feedback the manager after the first day supported staff to intervene when people were distressed in a supportive and positive manner. They reported no use of restraint in the week of the inspection and also the following week. However, although a positive improvement, this did not demonstrate that care had been delivered and managed in a consistently safe manner.
● Risks to people's physical health needs, such as epilepsy, were identified and reviewed and measures were put in place to reduce the likelihood of harm occurring.
● Staff were aware of how to evacuate the home in the event of an emergency such as a fire. A fire risk assessment had been completed along with regular fire safety checks. Staff also completed health and safety checks of the premises to help ensure people stayed safe.

Staffing and recruitment
● Sufficient staff had not consistently been deployed to meet people's needs. Staffing levels in the service did not ensure people could receive the assessed level of care they required.
● In the absence of a manager, staffing levels did not ensure a senior staff member had oversight of the service. Senior staff were included in staff numbers to directly support people, when they were responsible for the safe management of the service in the absence of a manager. In the event of an emergency, or where staff required assistance during a managers absence they were unable to effectively and safely respond.
● One staff member told us, "There are never enough staff, today we have [People] who are 2:1 then [People] who are 1:1. We have been just six staff, no manager, no team leader to support staff, give them a break of assist if there is a problem. I've just done a 24 hour shift, no sleep in, we were worried about [Person] as they had an episode yesterday." We discussed this with the regional manager who agreed staffing had not been well managed.

Staff were not effectively deployed to safely meet the needs of people living in the service. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During the inspection, the manager took action to ensure staffing levels were in line with people's assessed needs. However, prior to this staffing was not sufficient to safely support people.

Using medicines safely
● People received their medicine as prescribed. Staff administering medicines were trained and their competency reviewed.
● People's medicines were managed safely. Records were completed when medicines were administered, and stocks checked tallied with the records held. Checks were in place to ensure medicines were safely stored.
● Medicines required on an 'As needed' basis had clear instructions for staff to follow.

Preventing and controlling infection
● Some areas of the service required cleaning due to spills and daily living. Staff and the regional manager

told us that they encouraged people to clean their living areas. However, we saw that some staff did little to support people with their living skills.

● Sufficient equipment was in place for staff or people to use to keep the home clean and prevent infection. Staff were trained and aware of infection control procedures.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

● Not all staff had received training to support people. For example, staff had not been provided training to communicate with a person using sign language. Staff had also not had sufficient training to positively support people when they became distressed. One staff member said, "It's ridiculous that [Person] is trying to talk to us and [Provider] can't organise British Sign Language training. [Regional manager] told us this was being organised months ago but like most things it never came."

● Staff told us they were not supported to develop in their job roles and did not find supervision sessions helpful. One staff member said, "Supervision is just a list of instructions and what we are doing wrong, they're not helpful or make me want to develop." Appraisal records showed that only 20 percent of staff had received their annual appraisal.

● Records showed staff had completed training in some key areas although there were some gaps. Only 70% of staff had completed epilepsy and 74% had completed basic life support training for example.

The provider had failed to ensure appropriate and consistent support, training and appraisal was provided as is necessary to enable staff to carry out the duties they are employed to perform. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

●The provider and manager responded immediately during and after the inspection. They confirmed appropriate training had been sought and booked and an action plan was in place to address staff supervision and appraisal.

Supporting people to eat and drink enough to maintain a balanced diet

● People had not been consistently supported to maintain a balanced diet. On the first day of the inspection, people did not have sufficient food to prepare a balanced meal. The regional manager had not ensured sufficient funds were available for staff to shop.

● Staff told us they had brought food from home for people as they did not have any available in their kitchen. People had requested snacks which were unable to be provided due to a lack of funds. Menus were developed with people; however, they did not promote a varied and healthy diet. People were not actively encouraged to make healthy choices with their meals.

● People had refused meals at times as there was no alternative when cooking an evening meal for all people. The lack of food had caused some people to become upset and had led to incidents with the staff

team.

We found no evidence that people had been harmed, however systems were not effectively managed to ensure people had sufficient food available. This was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider ensured funds were immediately made available and the manager ensured food had been purchased when we visited on the second day.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People had received an assessment prior to moving to Chaseways. However, this wasn't always accurate and no action had been taken to complete their own assessment of people's needs when it was found to be inaccurate . For example, one person moved to the service and it noted they displayed behaviours that may place them or others at risk in the community. However, no examples of this behaviour had been observed. Staff assessed the person as requiring 2:1 support based on this when out of the building but there appeared to be no basis for this restrictive decision. The provider identified this in an October 2019 quality review. However, no further review of assessment had been completed.
● There was some monitoring of restrictive practice, however this what not always effective or done as part of people's wider person-centred support planning and in line with recognised best practice.

Ensuring consent to care and treatment in line with law and guidance
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 can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

● Staff were able to describe how they sought consent, and how they obtained this when people may not be able to provide this. We saw copies of some assessments which accurately assessed people's capacity and considered, where appropriate whether decisions were in people's best interest.
● There were examples of staff making decisions for people who were unable to make choices for themselves. For example, what activities people wanted to do or support with legal matters.
● The guidance within the Mental Capacity Act 2005 had not been followed and best interest decisions had not been made by involving the relevant parties, such as health professionals and families.
● DoLS applications had been submitted to the local authority, although whilst awaiting a decision a risk assessment or care plan to manage the deprivation had not been developed.
● One DoLS had recently been refused as the person was assessed by the DoLS assessor as having capacity. Little had been done to review this person's care in relation to restrictive practices, however the manager had identified this and was reviewing this evidence.

Adapting service, design, decoration to meet people's needs

● The service had been designed to meet people's needs. Communal areas were large which gave people space to take part in daily living skills and have their own space.

● Some areas of the service required decoration. For example, a window's handle had been broken for a number of weeks and only repaired when we raised it as a concern. Other areas of the home required decoration to the walls and ceilings to repair cracks and damage.

● Bedrooms were personalised, and had en-suite showers. Each 'flat' was fully equipped and furnished with access to a large garden which people could enjoy.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● People were not always supported to lead healthier lives. People's nutritional needs had not been met and people were placed at risk of harm through poor risk management. We have reported on this in the effective and safe domain.

● People were supported to see health professionals such as GP's, social workers, psychiatrists and mental health teams. The advice from these professionals was added to people's care and support plans and shared among the staff team.

● Staff accompanied people when attending appointments both within the service and when visiting places such as hospitals or GP's.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- We found five breaches of regulation at this inspection. Some of these areas had been identified by the provider before our inspection, however we found further areas of breach not identified. Where the provider had identified concerns, these had not been addressed in a timely manner.
- In the absence of a registered manager, the provider had not ensured effective manager oversight.
- The provider had not ensured safe deployment of staff and there were no effective systems in place to ensure any shortfalls were identified.
- Staff reported to the interim manager where there had been an incident or concern. However, these were not reviewed in a timely manner. We saw incidents reported awaiting review from three weeks prior to the inspection. These incidents all related to people becoming distressed.
- The provider had a system in place to record and learn from incidents, but this was not used effectively. Themes, patterns and trends emerging were not analysed to see how care could be improved.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Staff morale in the service was poor. One staff member said, "I have looked to work elsewhere but I stay because I want to make sure [people] are safe."
- Staff told us they had not felt comfortable to raise concerns with the previous management team and they felt their feelings and views were not important. However, staff were positive about the appointment of the new manager. One staff member said, "[Manager] has only been here a couple of weeks but already is more supportive of us. They are not hanging about and now are just getting on putting things right. I think it will be much better now they are here."
- Staff told us they regularly reported concerns to the regional [interim] manager but these were not followed up. One staff member told us about a person whose money was managed by an appointee. They had little clothing, and none that was appropriate for the cold weather. They reported this, but we found the interim manager had not contacted the appointee for funds to buy new clothing. Staff also had reported a lack of petty cash for shopping that led to a shortage of food for people among numerous other concerns.
- Care was not always person centred and while we observed some caring interactions we also observed a staff team focused on completion of tasks
- We reported our findings to the provider who took appropriate action including sending the human

resources team to the service to support staff.

The provider had failed to effectively monitor the quality and effectiveness of the service. This was a breach of regulation 17 (Good governance)) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The interim manager and staff were not clear on when duty of candour applies. We saw that where incidents occurred, that had caused harm or could lead to a significant risk of harm, management did not act in an open and transparent manner in all instances.
- For example, when people were restrained unnecessarily the interim manager did not always inform professionals and relatives or apologise to people for doing so. People and their relatives were not told what safety measures would be taken or what enquiries or investigation would be carried out.

The provider did not ensure that duty of candour was followed and that they acted in an open and transparent way. This was a breach of regulation 20 of the Health and Social Care Act 2008 [Regulated Activities] Regulation 2014.

Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The views of people, relatives and staff had been sought about the quality of care they received through a survey and helped people have input into menu choices. However, we found that meal choices had been made by staff based upon the availability of food on a day to day basis. This did not ensure people were engaged with decisions about their day to day care.
- Hours provided by the local authority for people to be engaged in meaningful activity were not provided.
- The service worked with local health professionals when needed and supported people to attend their appointments.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (a) (b) Safe care and treatment. People were not protected from the risks of unsafe care as staff did not ensure they did all that was practically possible to avoid the use of restraint. Care was not provided in a safe way that kept people safe from the risk of harm.

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 (1) (2) (3) Safeguarding service users from abuse and improper treatment. People were not protected from the risk of harm. Systems were in place but not operated effectively to investigate incidents when reported to the responsible individual.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Regulation 14 (1) The nutritional needs of people was not met due to a lack of food available to sustain good

health.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) Good governance. Governance and oversight of the service did not identify areas of improvement. Management arrangements in the service were not sufficient to keep people safe from harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour Regulation 20 (1) Duty of Candour The provider did not act in an open and transparent way in relation to care and treatment provided to service users in carrying on a regulated activity.