Mrs S Dewing

Chiswell Residential Home

Inspection report

193 Watford Road
Chiswell Green
St Albans
Hertfordshire
AL2 3HH
Tel: 01727 856153

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Ratings

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

Overall summary

Chiswell Residential Home provides accommodation for to up to six people who require support with their personal care needs.

This inspection took place on 15 October 2014 and was unannounced. At our last inspection in October 2013 we found that the service was found to be meeting the required standards. At the time of our inspection there were six people living at Chiswell Residential Home.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

People were supported by staff who knew them well but did not always have the necessary skills to support them appropriately. We found that staff training was out of date and some staff did not have the training required to

Summary of findings

deliver the care that people needed. Staff were caring and knew how to protect people's dignity. We saw kind and caring interaction between staff and the people they cared for.

People were supported to see their GP and other health care professionals. They received regular visits from the community nurse and the community psychiatric nurse (CPN) where necessary. However, we found that people were not supported to go out into, or be involved in, the wider community.

Staff were clear about their roles and felt they were supported by their manager. There were staff and residents meetings held to obtain people's views and concerns but these were not used to develop the service.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005, Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection no applications had been made to the local authority in relation to people who lived at Chiswell House Residential Home.

Staff did not follow requirements of the MCA 2005 regarding people who lacked capacity to make their own decisions. The provider had not made a DoLS application for one person even though we found their liberty had been restricted.

At this inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This related to the lack of assessment of peoples capacity and consent to care, the level of training some staff had received and a failure to monitor the quality of the services. We also found the service was in breach of the Health and Social Care (Registration) Regulations 2009. This concerned failures to notify CQC about certain incidents that happened at the service. 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?

Requires Improvement

The service was not safe.

Restrictions imposed on some people restricted on their freedom of movement in a way that contravened requirements of the MCA 2005 and published guidance.

The provider had failed to notify CQC about certain incidents and accidents that occurred at the service.

Medicines were not always managed safely because 'as required' (PRN) pain relief tablets could not be properly accounted for in all cases.

Is the service effective?

Requires Improvement

The service was not effective.

Some training was out of date which meant that people may not have been cared for by staff who had the necessary skills and knowledge in all cases.

People were supported to eat and drink sufficient amounts.

Staff did not understand the Mental Capacity Act and deprivation of liberty safeguards. The service did not ensure capacity assessments were completed in all cases where necessary.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff knew the people they supported and we noted good relationships between the staff and people who used the service. Positive comments were received from family and people who used the service.

People's privacy and dignity were respected.

People who used the service and their families were not always involved in planning and making decisions about their care.

People's personal information and medical histories were not always treated with the required levels of confidentiality.

Is the service responsive?

Requires Improvement

The service was not responsive.

People were encouraged by staff to raise and discuss any concerns they had.

There had been no activities co-ordinator for some time and people were not supported to access the community.

People's individual health and care needs were always met.

Summary of findings

Is the service well-led?

The service was not well-led.

The manager was highly regarded by staff and was available to cover shortages when required.

People were not supported to access the community.

There were no arrangements in place to manage the home effectively when the manager was not present.

There were staff and service user meetings held for obtaining people's views. However, actions were not taken to address issues raised as a result of these meetings.

There were no performance or quality audits undertaken to help develop the service.

Requires Improvement

Chiswell Residential Home

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 met 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 under the Care Act 2014.

This inspection, which was unannounced, took place on 15 October 2014 and was carried out by two inspectors.

Before the inspection, the provider completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what they plan to improve. We also reviewed information we held about the service, including statutory notifications and enquiries. Statutory notifications include information about important events which the provider is required to send us by law.

During the inspection we spoke with four people who used the service, two relatives, the registered manager and three staff members. We received feedback from health care professionals, stakeholders and reviewed the commissioner's report of their most recent visit. We viewed four people's care documentation and three staff recruitment files. We carried out observations throughout the inspection.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at the home. One person said, "I am happy here." A member of staff told us, "We keep an eye on people to make sure people are safe."

We saw that there was a child safety gate on the first floor that separated two bedrooms from other areas in the home. Staff told us that the gate was there to prevent people from falling down the stairs or wandering into other people's bedrooms. People who used the rooms in question were unable to operate the gate without support from staff members. This meant their freedom of movement was restricted when the gate was closed. We spoke with staff and the manager about this who told us that risk assessments had not been carried out regarding use of the gate. They

were not aware that the gate amounted to a deprivation of people's liberty and had not therefore, documented the decision or made a DoLS applications in line with requirements of the MCA 2005.

Staff did not have a good understanding of safeguarding vulnerable people. For example, we asked one staff member how they keep people safe. They told us, "If I see a bruise I record it in their care plan and fill out an accident report form, but I haven't seen any bruises." Another staff member said, "We make sure residents are safe in this home, we make sure knives and medication are locked away. People are not allowed in the kitchen for their own safety." We found that no risk or best interest assessments had been completed. Staff managed concerns about safety and risks by restricting people's movement.

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

We found staffing levels were sufficient to meet people's needs. There were procedures in place to cover staff shortages. We saw that the recruitment policy had been followed and staff had been subject of appropriate checks. We observed staff respond to people's needs promptly. One relative said, "This is a small home so [name] gets more personal attention."

We saw people received medication safely. The medication that people received had been recorded on medication administration records (MAR) sheets and was securely stored. Medication was delivered to the home regularly and all unused medication was returned to the pharmacist. However, we found that medicines stored for pain relief as required (PRN) were not always accurately recorded. It was not always clear from the MAR sheets when a person had been administered PRN and the tablets could not be properly accounted for. This meant that PRN medicines had not been managed in accordance with published guidelines.

Staff told us, and our inspection confirmed, that there had been incidents at the home that required risk assessments to be conducted in order to protect the safety of people, staff and visitors. We spoke to staff who told us they had managed incidents but had not updated peoples care plans. For example, one incident involved a situation where a person had left the home unsupported and was later found outside. No assessments had been completed or guidance made available to staff to identify, manage and reduce the risks involved.

We saw that staff restricted people from entering the kitchen on a number of occasions throughout the day. We asked staff about this and they told us that they had stopped people entering the kitchen as there were appliances and utensils which posed a risk of harm. No other options had been considered for supporting people to use the kitchen. Staff had also been advised not to allow one person to help hang out washing as it may put them at risk and render them breathless. There had been no risk assessments or involvement with the person about this decision. This meant that people were not supported to take risks that may have promoted their independence safely.

Is the service effective?

Our findings

People told us that staff were good at their jobs. One relative said, "This is a good home, my [relative] gets more attention here." Staff told us that they received regular supervisions and appraisals and the manager confirmed this.

However, we found there were no systems in place to monitor when staff required training to ensure their skills and knowledge was both up to date and relevant to people's needs. The manager told us they had informally checked training certificates on an ad hoc basis to identify what training was required. We found that in some areas staff had not received training since 2012 and 2011. This meant that people may not have been supported by staff with the necessary knowledge and skills in all cases.

Staff were unable to describe safeguarding procedures and had not completed this element of their training. The manager told us that a community psychiatric nurse provided updates for staff in some areas of care relevant to people who lived at the home. However, they were not a qualified trainer and the manager had not satisfied themselves that the training provided was current or in line with best practice. The manager told us they had not put any development plans in place for individual members of staff. This meant there were no suitable arrangements in place identify training needs or to support staff develop skills and abilities relevant to their roles.

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

We found that people had not been assessed to see if they had capacity to make their own decisions about their care. Staff were not aware of the Mental Capacity Act (MCA) 2005 or Deprivation of Liberty Safeguards (DoLS). We found that where people may have lacked capacity to make certain decisions, this had not been assessed in accordance with the MCA 2005.

The manager had not involved health and social care professionals or relatives when decisions were made in people's best interests. We were told by staff that one relative had signed a letter to say that the senior care staff could make decisions relating to their relatives care. However, no assessment of the person's capacity to make decisions had been carried out. This meant that decisions may have been made for people that were not in their best interests or in line with the MCA 2005 and published guidance.

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

One person told us that they felt the best thing about the home was the, "Good food." We observed that people were supported to eat independently and staff were attentive and patient. There were a number of conversations taking place over lunch and the food and drinks were served in a calm, friendly and relaxed atmosphere. The food was home cooked and prepared fresh at people's request. Drinks and snacks were available throughout the day. We looked at the menu choices available and found that healthy home cooked meals were provided every day.

The menu had been developed by staff to accommodate people's preferences, nutritional needs and dietary requirements. One visitor said, "My [relative] is fed really well and always has home cooking."

We found that a range of health care professionals had visited people regularly at the home. These included GP's, chiropodists and district nurses. We saw that people had been referred for specialist treatment where required to in a timely manner. This meant that people received care that met their needs and were supported to maintain good health.

Is the service caring?

Our findings

We found people's care records, which contained personal information relating to their care and treatment, were located in the kitchen on open shelves. These were easily accessible and could be accessed by anyone who entered the home. All of the records contained sensitive and confidential information. This meant that people's personal information and medical histories had not been treated with the necessary level of confidentiality in all cases.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were positive about the care provided. We saw good interaction between staff and people who used the service. We observed staff knock on people's doors and wait for a response before entering. We observed and heard friendly respectful communication from staff. One person who used the service said, "Staff are nice." A relative told us, "I am happy with the care that [relative] receives." Another relative told us, "Staff are really respectful, this is a good home."

Staff were knowledgeable about the people they supported. They were able to tell us about people's likes and dislikes and their basic care needs. Staff were also able to tell us about people's individual medical conditions and their personal care requirements.

Staff told us that relatives and visitors were welcome into the home at any time. This encouraged good contact with family members and helped the people to maintain these relationships. There were two relatives at the home when we arrived for the inspection and we spoke to one relative who told us that, "[Name] is always relaxed when we visit."

The manager told us they have residents meetings to support people's needs; "We ask people what they would like to do." We observed that people were happy and relaxed in the home. We saw that staff encouraged and supported people. For example, we saw that people were asked if they would like to do a puzzle. People were frequently asked if they needed anything such as a drink or reading material.

People were not encouraged to choose to go out and were not fully involved in these decisions. Staff felt that they listened to peoples views when they told them they did not want to go out. Staff did not explain the opportunities available outside of the home in a way that they would understand or promote people's independance. This meant that people chose to stay within the home and could be missing out on the development opportunities available to them.

Is the service responsive?

Our findings

There were no meaningful activities provided at the home available which reflected people's social interests or hobbies. The person responsible for activities had been off for many months and there had been no replacement. On the day of our inspection we observed one person complete a puzzle. This was the only activity that took place. There were four people in the lounge during our inspection, three people watched television and one slept. Apart from at mealtimes people remained in the lounge.

Staff told us, and records confirmed, that there were no regular outings into the community and people were not supported to follow their interests. In one person's life history it noted their religious background but this was not supported in the home. We spoke with staff about this who told us that it was the responsibility of person's family and not the home support them in their religious beliefs.

This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

One relative told us that they had been involved with the care planning for their relative and they were happy with the care provided. They also said, "This is a good home because it is small and my [relative] gets more individual attention." Another relative said, "We are absolutely happy with the home and care they provide."

One person told us, "I don't like to go out." One relative said, "My [relative] probably wouldn't like to go out because they don't like crowds." We saw in one person's care plan that they should be encouraged to have daily walks and in good weather to walk outside to improve their quality of life. However, we found that people were not supported to leave the home. We were told by staff that people did not want to go out. Staff told us that one person did attend a day centre for one day a week. We found the home had not reassessed people's changing needs and did not know whether people would like to go out as they were not asked regularly.

The homes statement of purpose stated. "Chiswell Residential Home recognises that risk taking is part of everyday life." However, we found that people were not supported to take well managed and proportionate risks. It also stated that staff would; "Support and facilitate people in activities in the local community." We found people were not supported to access the community and the home did not promote its own values. This meant people were not supported to be independent and they had restrictions put in place that were meant to keep them safe. There was no positive risk taking. People were not encouraged to participate in activities that would promote their independence as the statement of purpose suggested, for example, being encouraged to bake a cake.

We found that although care plans gave details about people's care needs and assessments, these were basic. Staff told us that one person could become very agitated, but there were no trigger points detailed in the care plan and no guidance for staff about how to manage the person's behaviour effectively. The care plans contained peoples preferred names and we heard staff using these names when they communicated with people.

We noted that there were complaints policies and procedures displayed in the home. We asked the staff how people were supported to express their views, one staff member said, "We have good communication with people and we always ask if everything is alright. If someone complains we would put this in the daily report and we talk with people to discuss any issues." The manager told us that they had received no complaints but people's views were sought in meetings. One relative said, "If they had to complain they would just speak to the manager."

Is the service well-led?

Our findings

We found that the service had not met legal requirements for submitting notifications to CQC about certain incidents that had taken place at the home. For example, we received a notification sent 19 September 2014 about a fall that resulted in a fracture. The incident had occurred the previous year on the 18 September 2013.

The provider told us they were not aware of the requirement to submit notifications promptly when serious incidents occurred. They shared details of several incidents that should have been notified to CQC but had not been. This was rectified on the day of the inspection and, although they had not been reported in accordance with the Regulations, a review of the incidents showed they had all been managed appropriately at the time.

This was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People who lived at the home and staff were positive about the manager because they were approachable and demonstrated a 'hands on' approach to their role and the care provided. One staff member said, "I feel supported by my manager, they are very good."

However, we found that staff were not always clear about their roles, responsibilities or what was expected of them, particularly in the absence of the manager. This was because they did not have a shared understanding of potential risks and had not been provided with adequate guidance, training or support to perform their roles effectively. For example, staff were not sufficiently aware of the requirement to inform CQC about certain incidents, the need to carry out individual risk assessments to promote people's independence or their responsibilities concerning deprivation of liberty standards and the MCA 2005.

The manager had not provided the leadership and support necessary to develop and support the staff team or to drive improvement at the home. For example, effective systems had not been put in place to ensure that training needs were assessed and staff kept up to date with the training required to perform their roles and meet people's needs. We found that plans had not been put in place to help, encourage or support individual staff members to develop or improve performance by learning new skills.

Effective systems had not been introduced to monitor the quality of services provided at the home or to identify, manage and reduce potential risks. We found that, although people were encouraged to raise concerns and suggestions about how the service operated, the information obtained had not been used to develop action plans and drive improvement. The manager told us that they did spot checks to highlight areas that required improvement.

However, the outcome of these were not recorded or action takenand we found areas of concern that had not been identified. For example, PRN medicines and people's confidential information had not been managed effectively and care plans lacked the both information and risk assessments necessary to help people access the community and pursue their interests.

We asked the manager and provider to tell us what they thought was good about the service. The provider information return (PIR) submitted did not contain any information about what was considered good. We also asked for information about any future improvements planned to improve the quality of management and leadership at the home. The response provided was; "None whatsoever."

This was in breach of Regulation 10 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	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse We identified that the service was in breach of Regulation 11 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider did not have suitable arrangements in place where any form of control or restraint is used in the carrying on of the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment We identified that the service was in breach of Regulation 18 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010. Peoples had not given consent and capacity assessments had not been done

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff We identified that the service was in breach of Regulation 23(a) 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 provider had no suitable arrangements in place to ensure staff were properly trained to meet people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records We identified that the service was in breach of Regulation 20 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider did not ensure people's records were kept securely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services We identified that the service was in breach of Regulation 17 (1) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People's autonomy, independence and community involvement were not supported.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment We identified that the service was in breach of Regulation 18 (1) (a) (ii) of the Care Quality Commission (Registration) Regulations 2009. The provider did not notify the commission of incidents that had occurred

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	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers We identified that the service was in breach of Regulation 10 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider did not have effective systems in place to regularly assess and monitor the service. Identify assess and manage risks relating to the health, welfare and safety of the service user.