Mrs S Dewing

Chiswell Residential Home

Inspection report

193 Watford Road
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on the 4 February 2016 and was unannounced. Chiswell Residential Home is registered to provide accommodation and personal care for up to six older people with mental health needs. On the day of our inspection there were five people living at the home.

At the last inspection on 15 October 2014, the service was found to not be meeting the standards in relation to safeguarding people from abuse; obtaining consent; supporting staff; record keeping; respecting and involving people who used the service and the quality monitoring of the service. We found that the provider had made significant improvements and was now meeting most of the regulations. However, people had not had their capacity assessed and applications to deprive people of their liberty were not in place. Record keeping still required further development and action plans were in place to help ensure they achieved the required improvements.

There was a registered manager in post. 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 2008 and associated Regulations about how the service is run.

People received care that met their needs and staff knew them well. People were involved in planning their care where possible. There was some family contact however this was minimal due to distance so people's relatives were not routinely involved in people's care and support planning.

Staff had been trained and this was being reviewed and developed as part of the on-going action improvement plan. We found that staff were able to recognise any signs of abuse and knew how to report concerns. There were adequate numbers of staff on duty to meet their needs safely at all times.

People were supported to live as independently as they could. Risks to people`s health, safety and wellbeing were identified and actions were put in place to reduce risks to people when possible. People were encouraged and supported to participate in activities and hobbies; this included some events in the community and shopping trips.

There was a robust recruitment procedure in place to help ensure that staff employed were suitable to work in a care setting. Staff employed at the service had completed an induction when they commenced working at the home and had received some training updates relevant to their roles.

People`s medicines were administered safely and staff had received training. There were systems in place for the safe storage of medicines and we saw that medicine records were completed correctly.

People who used the service felt they were treated in a kind and caring way. Staff respected and promoted people's privacy and dignity. People were supported to maintain their health and wellbeing.

The Mental Capacity Act (2005) provides a legal framework for making particular decisions on behalf of people who may lack 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. Where 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS)

We checked whether the service was working in line with the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that people living at the service were not always able to make their own decisions. We found that people who had been identified by the provider as not having the ability to consent had not been formally assessed or reviewed under the MCA. This meant that some people who lived at the home could be being deprived of their liberty unlawfully. The manager and staff had some understanding of their role in relation to DoLS, but were seeking further support in respect of the completion of MCA assessments.

The provider had a procedure in place for dealing with complaints and concerns. There were some quality monitoring processes in place and these were being developed by the provider. The provider had commissioned an external quality monitoring survey and was in the process of putting actions in place in response to recommendations.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were kept safe. Staff were staff trained to recognise and respond appropriately to potential abuse.

Staff were recruited through robust recruitment processes to ensure that staff were suitable to work in a care home environment.

Sufficient numbers of staff were employed and available to meet people's individual needs at all times.

People were given medicines by staff who had been trained to administer medicines safely.

Potential risks to people's health and well-being were identified and actions put in place to reduce the risks.

Is the service effective?

Requires Improvement

The service was not always effective.

Mental capacity assessments and best interest decisions had not been carried out where necessary in accordance with the requirements of the MCA 2005.

People's wishes and consent were obtained where possible before care and support was provided.

Staff were trained and supported to help them meet people's needs effectively.

People were assisted to eat a healthy and varied diet which met their needs.

People had their day to day health needs met with access to health and social care professionals when necessary.

Is the service caring?

Good

The service was caring.

People were cared for in a kind and caring way by staff that knew them well and were familiar with their needs.

People, where possible were involved in the planning, delivery and reviews of the care and support provided.

People's privacy and dignity was maintained.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support that met their needs and took account of their personal circumstances.

People were supported to participate in activities and hobbies, both in the home and local events in the community.

People were aware of how to raise concerns and were confident that any concerns would be dealt with positively.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The systems that were in place were not always effective in monitoring all aspects of the service, in particular records were not always consistent and or robust.

Records were not always adequate and processes were not always evident.

People, and staff were complimentary about the manager and how the home operated and was managed.

Staff understood their roles and responsibilities and felt supported by the manager.

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 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.

The inspection was carried out on 4 February 2016 and was unannounced. The inspection was undertaken by one Inspector. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that requires them to give some key information about the service, what the service does well and improvements they plan to make. In addition to this, we also reviewed all other information we held about the service, including statutory notifications which are specific events which the provider is required to tell us about and feedback from people who commission the service.

During the inspection we spoke with three people who lived at the home, a member of staff and the registered manager who is also the provider. We also received feedback from health care professionals who are familiar with the service and the people they supported. We looked at care plans relating to two people, we looked at two staff files and reviewed other documents relating to the overall monitoring of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to complex health needs. We observed staff interaction with people who used the service to see if people were treated in a kind, caring and compassionate way.

Good

Is the service safe?

Our findings

People told us they felt safe living at Chiswell house. One person said, "I feel safe living here I have lived here for many years and have got used to the people and the staff and I feel I am in a safe environment." Another person said, "I feel safe here, but I would not feel safe going out in the community without staff, I have lost my confidence a bit. But I have no concerns about living here at all." Staff were able to tell us what constituted abuse and how they would report any concerns. In the office we saw a 'protecting adults from abuse' poster and the contact details were documented as a constant reminder for staff and people who used the service should they need to report any concerns. A member of staff told us they would have no hesitation in reporting any concerns to the manager, or externally if required.

People had risk assessments completed to help keep them safe and ensure that risks to their health and welfare were reduced where possible. Staff told us they worked in accordance with the risk assessments. However, the risk assessments were not always reviewed regularly. There was however nothing to suggest that people had been put at risk as a result of this. Staff and the manager told us they worked with people on a daily basis and were a small care home and knew the people they supported very well. Staff and the manager gave us some examples of the risks and demonstrated how they had taken action to mitigate the risks. For example, where there had been a deterioration in a person's mobility, they were assisted with a walking aid to help reduce the risk of them having a fall and to help keep them safe.

There was a book for recording accidents and incidents, however none had been recorded since our last inspection and the manager told us there had not been any accident or incidents.

There were adequate staff on duty to support people safely at all times. We saw that people's needs were met in a timely way and receive any support as needed. The rota demonstrated this also. Staff told us that there was a small team of regular staff and if anyone was unable to work at short notice, the shift was covered by another member of the team. The manager also worked alongside staff regularly. People were supported by staff who had been recruited through a robust recruitment procedure. This included completing an application form, an interview, written and verified references and a criminal records check. These checks helped to ensure that staff employed were fit to work in a care home environment.

People's medicines were managed safely. We saw the manager administer medicines to people and saw that they worked in accordance with safe working practice. Medicine records were completed appropriately. There was a medicines policy and procedure in place and staff had been trained to administer medicines safely. There were regular stock checks of boxed medicines to help ensure they were being administered in accordance with the prescriber's instructions. Medicines were audited weekly to ensure any potential errors could be picked up quickly and remedial action put in place.

Requires Improvement

Is the service effective?

Our findings

People were supported by staff that had the appropriate skills, knowledge and experience. Staff were supported by the manager and received regular supervision.

Staff completed an induction programme when they commenced employment. They also received training relevant to their roles within the service. The training included topics such as moving and handling, food safety, administration of medicines and infection control. Staff told us that the training they received was appropriate and helped them provide support to people in their care. One member of staff told us they regularly worked alongside the manager, who observed competency to make sure staff maintained good working practices.

Staff told us they felt supported by the manager and received one to one supervision from the manager. However, we noted that the records were sometimes basic and did not detail fully the discussion points and agreed actions. The manager told us this was because they were such a small home and they worked alongside staff on a daily basis so processes were much more informal. Staff and the manager told us they had meetings but these were not minuted as there were often only two or three people in attendance. This meant it was difficult for us to assess how effective the staff support processes were and the manager agreed that the process needed to be more formalised and to be able to demonstrate that there were systems in place to support staff. This was an area that the manager was working on so they could demonstrate the frequency and effectiveness of the meetings.

The Mental Capacity Act (MCA) 2005 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the provider worked within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We spoke with the manager about MCA assessments and they told us these had not been completed to determine whether people had capacity to make specific decisions. This meant that people may have been deprived of their liberty unlawfully. The manager told us that people did not go out of the home alone as they would require supervision and support from staff to ensure their safety was maintained. The provider who was also the registered manager and staff had some understanding of their roles in relation to DoLS, but were seeking further support in respect of the completion of MCA assessments.

Staff understood the importance of ensuring people who could give their consent gave their consent to the care and support they received. We observed staff asking people if it was alright to provide support and giving them choices. For example, people were asked about what they wanted to eat and drink and how

they wished to spend their time.

People were supported to eat and drink a balanced and varied diet to support and maintain their health and well-being. We saw that people were offered choices and the menu was planned daily so that people could choose what they wanted to eat each day. One person told us, "I love the roast dinner on a Sunday, it is my favourite." We saw people had regular hot and cold drinks throughout the day.

People's healthcare needs were met by a range of healthcare professionals who visited the home. We saw that people were supported to attend appointments with dentists, opticians and GP's. People also had a folder that contained a summary of their needs in the event of an emergency. This included any medical conditions, allergies and what medicines they took regularly. This meant that people's health care needs were supported to help ensure they received effective care consistently.

Good

Is the service caring?

Our findings

People told us that staff were kind and caring, and we observed this to be the case throughout the inspection. One person told us, "I like living here, the staff are very thoughtful and kind." Another person told us they could not think of anything they would change as the home and care, "was everything they needed".

During our inspection we saw that staff helped and supported people in a kind and caring way while respecting their privacy at all times. Staff asked people for permission before entering their bedrooms to provide support and also when assisting them personal care. We saw that people were engaging positively with staff and the manager. Staff were respectful of people's wishes, taking time to listen and wait for the person to respond before supporting them.
A social care professional told us, "The care and support people get is good here.", however systems and processes are a little informal here but we are working with the provider to improve this". We saw that staff treated people with dignity and respect. A member of staff told us, "We treat the people who live here like their own family, we care for them and about them."

Staff had developed positive and caring relationships with people who lived at the home. They were very knowledgeable about people's individual care and support needs and people's personal circumstances. For example, staff knew what made people anxious or worried and they tried to be proactive so as to minimise the likelihood of people becoming anxious or distressed. Staff used effective communication methods to reassure and calm the people in a kind and respectful way. For example they faced people and bent down to their level and spoke slowly and smiled, they then waited for the person to respond as a way of checking that people had understood what was being communicated.

People were supported to maintain positive relationships with friends and family although most of the relatives lived some distance away but visited when they could. We saw that relatives were kept informed of important events where appropriate and were invited to visit the home at any time.
People told us they were asked to be involved in the planning and reviews of their care where this was possible. The manager and staff confirmed this was the case. However, two people told us they did not feel they needed to be involved as they were happy with the support they received. They also told us the staff and manager always asked them before helping them and they could 'speak up' if they wanted to change anything. Each person had a key worker assigned to them who was responsible for ensuring they received the support they required.

Some of the people who lived at the home lacked capacity to make certain decisions for themselves and we found that people had limited support from family, mainly because they lived far away. We asked the manager whether these people were offered support from independent advocacy services. The manager told us that people could be supported by advocacy services and this would be promoted more rigorously going forward. However the people we spoke with were not aware of the advocacy service and had not used the advocacy service previously.

Records and information was held securely. People's confidentiality was maintained and people had

consented to their information being shared or discussed with healthcare professionals.

Good

Is the service responsive?

Our findings

People received care and support that met their individual needs and took account of their wishes. Information was provided to help staff provide care in an individualised way but sometimes lacked detail. For example, about the person's background and individual likes and dislikes and how they preferred to be supported, and what they enjoyed doing.

People told us they could choose what time they got up and went to bed for example but the detail around this was not recorded in individual support plans. Staff knew people's preferred routines. People told us that they were given choices and offered alternatives.
The manager and staff told us that they were responsive to people's changing needs. For example a person whose condition had deteriorated requested they be cared for at the home and not to be sent to hospital. The manager ensured the person's needs were met and was supported in doing this by other community healthcare professionals who visited the home regularly. This included support from the community nurse and a speech and language therapist to assist with dietary changes. These arrangements ensured the service could respond to people's changing needs and wishes.

People were involved in a variety of activities. For example, one person was doing a puzzle, another was doing quizzes in a book and another was reading. Gentle background music was playing in the front lounge and the television was on for people to watch. Two people told us they had "their own interests, and just kept themselves occupied". Another person told us that, "When the weather is good, we go out sometimes to the coffee shop or garden centre as well as shopping trips". On the day of our inspection people had chosen to have a takeaway lunch from a local fast food chain. One person told us they would enjoy more activities away from the home but understood the restrictions the weather placed on outdoor events. We spoke to the manager about this who confirmed they would review the activities arrangements to make sure people's social needs were met and opportunities for additional community activities and events were sourced.

People told us they had meetings to discuss how the home was running. We saw that these were recorded in a book. The manager told us actions were fed back but not always recorded and that this would be done in the future. We saw there was a complaints policy and procedure in place and people told us they would speak to the manager if they were unhappy about the service. No complaints had been recorded since our last inspection as the manager told us any feedback would be addressed before it became a formal complaint.

An action plan template had been drafted so that any areas of dissatisfaction could be documented and pathway tracked so that actions could be signed off and an audit trail kept, and also as a way of identifying possible trends.

Requires Improvement

Is the service well-led?

Our findings

The service was not consistently well led.

The manager did not have effective processes in place and the arrangements for record keeping required improvements. However the manager and staff were very knowledgeable about people's care and support needs, a lot of the information was in their heads and this presented a risk. For example, if the manager or regular staff were not available a person who was not familiar with the people who lived at Chiswell house would struggle to fully support the people. The manager told us that they did not use agency staff currently. The manager agreed that records needed improving. They told us that providing good care had always been a priority and that paperwork was often put on hold.

We found that the provider did not always have robust processes in place to be able to demonstrate that the service was run both effectively and efficiently. For example, records, including care plans and risk assessments about people's individual health, care and support needs were not always as detailed and personalised or up to date as they should have been. We saw that care plans were basic, and were not regularly reviewed. Care plans did not demonstrate people's involvement, although they had been signed and consent had also been signed demonstrating some involvement but it was not clear if they had been asked to sign the document after completion.

Peoples care and support plans did not always accurately reflect people's involvement or choices about whether they wanted to be involved and this was an area that the manager was aware of which required more detailed record keeping.
There were inconsistencies in the files we looked at and we found information was difficult to locate. For example, risk assessments were only reviewed when there was a notable change to a person's condition which required intervention and so that prompted a review. However, routine reviews were not recorded. We discussed the need to formalise processes with the manager and the need to be able to provide supporting evidence to demonstrate what they do, how they do it and how often. Without these processes in place the effectiveness of the service could not be fully demonstrated or evidenced.

People who lived at the home were complimentary about the manager and staff. One person told us, "It's very homely here, we have good days and bad days, but overall they are a good bunch." The local authority contracts team had been supporting the manager with the development of some systems and processes but further work was required to provide a robust structured approach to all aspects of the service.

The manager was clear about their aims and objectives and the ethos of people first paperwork second prevailed. Staff applied the same values and told us that they were not too involved in the paperwork. One staff member said, "The manager completed most of the paperwork." Staff told us they understood their roles, responsibilities and what was expected of them.

The manager had commissioned a quality monitoring survey and had recently got the results back. Some recommendations had been made to improve the service and the manager was considering how these

areas could be developed. For example, how information relating to complaints was shared with people who used the service. Other feedback included that communication also could be improved and there was a suggestion to introduce a newsletter. The manager told us the home was too small for a newsletter and everybody was told about what was happening within the home. However, this was not always able to be demonstrated or evidenced and did not show that people were listened to.

There were some checks and audits in place relating to the overall maintenance of the home, for example gas and electrical safety checks, and the redecoration of the home. However there were no quality monitoring audits in relation to the overall quality of systems and processes which meant it was difficult to drive and measure improvements.