Chatting Independently Limited

Chatting Independently Limited - Orchard View

Inspection report

42a Wimblington Road
March
Cambridgeshire
PE15 9QN
Tel: 01354 650767
Website: www.chattingindependently.co.uk

Date of inspection visit: 3 & 11 November 2014
Date of publication: 13/03/2015

Ratings

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

Overall summary

This inspection was carried out on 03 and 11 November 2014. It was an unannounced inspection and was undertaken by two inspectors. The previous inspection was undertaken on 30 May 2013 and during this inspection we found that all of the regulations we looked at were being met

Chatting Independently-Orchard View is registered to provide accommodation and personal care for up to six people who have physical disabilities. People are accommodated on two floors which are accessed by a lift.

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

Summary of findings

providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection staff treated people in a way they liked and there were sufficient numbers of staff, although they did not all have the required skills to safely meet people's needs.

People were not protected from abuse because staff were not clear of the reporting procedures should they have any concerns about people.

People's needs were not clearly recorded in their plans of care which meant that staff did not have the information they needed to provide care in a consistent way. Care plans were not regularly reviewed to ensure that they accurately reflected people's current needs.

Most people spoke positively about the quality of food at the home. However, people were not provided with a diet that met their needs. Appropriate risk assessments were not in place in respect of eating and drinking and this put people at an increased risk of choking. People were not always appropriately supported with their eating and drinking at mealtimes.

The provider's monitoring and audit processes were ineffective and inadequate and had failed to identify issues in the home. Risks to people's health, safety and welfare were not appropriately assessed and managed.

Staff had not been provided with training opportunities to ensure they had all the required skills to carry out their roles.

There was a lack of an effective quality assurance system in place to monitor the service and ensure people received good quality care.

Our concerns about the safety and welfare of people were so great that we immediately informed the local authority of these concerns. As a result of our concerns the commissioners decided to remove all people from this home on 14 November 2014.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. 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?
The service was not safe.

Staff were not aware of the actions to take to ensure that people living in the home were kept safe from harm.

There were sufficient numbers of staff but they did not all have the appropriate skills to keep people safe and meet their assessed needs.

Staff did not have the required training to safely administer people's medicines.

Inadequate

Is the service effective?
The service was not effective.

Staff were not aware of their responsibilities in respect of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People were cared for by staff who had not received appropriate training to provide them with the care that they required.

People's health and nutritional needs were not effectively met as they were not provided with a diet that met their assessed needs.

Inadequate

Is the service caring?
The service was not always caring.

Some staff did not always respect people's privacy and dignity.

Some staff were knowledgeable about people's needs and preferences, especially in regards to their communication.

Most staff spoke with people in a caring and respectful way.

Requires Improvement

Is the service responsive?
The service was not responsive.

People's care plans did not reflect their current needs. However, people were supported to take part in their choice of activities, hobbies and interests.

People could not be confident that their concerns or complaints would be effectively fully investigated as there were no policies or recording systems in place.

Inadequate

Is the service well-led?
The service was not well led.

Inadequate

Summary of findings

There were a lack of opportunities for people and staff to express their views about the service.

There were no systems in place to monitor and review the quality of the service provided to people.

Chatting Independently Limited - Orchard View

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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.

This inspection took place on 3 & 11 November 2014 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection, we asked the provider to complete 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 improvements they plan to make. The provider completed and returned the PIR to us and we used this information as part of our inspection planning.

Prior to and during the inspection we spoke with the local safeguarding team who had highghted concerns around people's food and drink and they told us they were monitoring people's dietary needs, and had sought further support and advice from speech and language therapists.

We also looked at other information that we held about the service including notifications. Notifications are important events that happen in the service that we are required to be informed about by law. We also contacted the local authority safeguarding team for their views on the service.

During the inspection we spoke with four people who used the service, the registered manger, the provider, the deputy manager, five staff and two visiting health professionals. We undertook general observations in communal areas and during mealtimes. We looked at the interaction between staff and the people living at the home.

We looked at four people's care plans and other records related to their care such as medicines administration records. We looked at records relating to the management of the home including staff meeting minutes, service user quality assurance survey questionnaires, staff recruitment files and training records.

Inadequate

Is the service safe?

Our findings

Staff we spoke with were not clear about their responsibilities in relation to safeguarding people from harm. Whilst some staff were knowledgeable in recognising signs of abuse, they were unable to tell us who they would report their concerns to and were unable to locate the details of the local authority safeguarding team. Not all staff had received training in safeguarding.

On the first day of our inspection we identified two incidents that should have been reported to safeguarding. We spoke with the deputy manager and informed them of these concerns so they could take the appropriate action i.e. report the concerns to the local safeguarding team. Not having confidence that they would take the appropriate action we referred the concerns to the local safeguarding team. The following day we spoke to the deputy manager who stated they had not reported the incidents to the safeguarding team as they were not sure of the correct process for doing this and were waiting for guidance about what action to take from the provider. This put people at risk of further abuse.

This was a breach of Regulation 11 (1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Medicines were stored safely. Medicine administration records were in place and the recording of medication was accurate with the exception of one person's medications which we saw had not been signed as being administered on one occasion. We spoke with a member of staff who was administering medication and saw they did not follow the procedures set out in the homes policy. They informed us that they were not aware of the procedures in the policy and they had not had recent training in medicine administration. The medication policy stated "members of staff are trained regularly on all aspects of medicines held in the bungalow and the house". We also found that although none of the staff had received training in how to administer a medication which had been prescribed for use in an emergency situation, they were administering this. Between our two inspections to the home, we informed the provider that they must ensure that staff did not administer this medication until they had received the training, and that in the meantime an ambulance should be called if the medical emergency occurred.

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

We looked at four recruitment records and saw that all staff had been subject to a criminal records check through the disclosure and barring service. However, we also found that all of these records showed that references had been provided from personal friends of staff, that employment histories had not always been checked and references had not always been sought from previous employers. This meant that the required checks to ensure that only suitable staff were employed at the home had not been carried out.

This was a breach of Regulation 21(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Risk assessments were undertaken to identify risks to people who used the service but these were not always being followed by staff. For example, one person was at risk of choking when eating and drinking. Their care plan identified that, "supervision is required the whole time the person is eating and drinking". We noted that no members of staff supervised the person when they were eating their lunch. Staff were talking with each other or dealing with other people whilst the person was eating their lunch. Other risk assessments which were in place included the use of the hydrotherapy pool and the use of the lift. We found that these assessments did not contain clear instructions to staff to inform them of the action to be taken to minimise the risks to people's safety when using these. This put people at an increased risk of harm.

Staffing levels were determined according to the dependency levels of people who used the service and we noted that there were sufficient staff on duty to meet the needs of the people living in the home. We saw that staff responded quickly to people's requests and that staff had time to care for people. Staff told us they felt that on most occasions that there were enough staff on duty.

Inadequate

Is the service effective?

Our findings

During a safeguarding meeting which we attended on 3 October 2014, significant concerns were raised in respect of the safety of people when they were eating and drinking. These concerns were that people's eating and drinking guidelines were not being followed and that people were at a serious risk of choking. Assurances were given by the registered manager that guidelines written by a speech language therapist would be followed. However, when the Local Authorities Safeguarding Lead person returned to the home the following week they found that the guidelines were still not being followed.

During our inspection on 3 November 2014, we noted that staff were still not following the guidelines provided by the speech and language therapist (SALT) in relation to the type and consistency of food that people were to be provided with. This meant that people were at risk of choking.

Due to the concerns raised in relation to people not receiving the correct type of food and the risk of one person choking, staff from the local authority's Learning Disability Partnership had to attend the home at all mealtimes to ensure that people were receiving suitable food that had been prepared according to the guidelines.

All of the people we spoke with told us that they were able to choose their food and they shopped for this on a weekly basis. Snacks were available between meals for people to help themselves to or they could ask staff for some support to prepare these. Menus were chosen by each person and people were given choices about what they wanted to eat at every meal.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We received a copy of a letter from the chief fire officer following their inspection of the home on 1 September 2014. This letter raised serious concerns about a number of issues in relation to fire safety. During the inspection we found that the necessary actions had not been taken to ensure that people were protected against the risk associated with fire. Personal evacuation plans were not in place for all people living at the home and staff were not aware of the procedure to follow, should there be an emergency in the home which required people to be evacuated. Dangerous substances were not stored securely and combustible materials had not been removed from an escape route. The provider could not tell us why the work required by the fire safety officer had not been undertaken.

This was a breach of Regulation 15 (1) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us, and we found in records viewed that staff had not received appropriate training, supervisions and appraisals. Staff stated that they felt they were not supported and confirmed that the registered manager only came into the home about once every two weeks to talk to the people living in the home.

A newly appointed member of staff confirmed that they had not received any induction to the service. Senior staff confirmed that there was no induction in place for staff. We found that not all staff had received training in safeguarding, administration of medication, first aid, fire safety, epilepsy and infection control. The lack of induction, supervision, annual appraisal and support put people at risk of inappropriate or unsafe support.

This was a breach of Regulation 23 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager, deputy manager and other care staff, we spoke with were not fully aware of their responsibilities under the Mental Capacity Act 2005 and in relation to the Deprivation of Liberty Safeguards (DoLS). We were informed by the registered manager that there was no one currently living in the home who was being deprived of their liberty. However, there were no formal systems to show how people had been assessed or considered in the planning and delivery of care. In all records we looked at we saw, no one had received a formal assessment to establish their capacity for decision making. We also noted that people's care plans had limited information about how care was to be provided in the person's best interests or their preferences for how their care was to be delivered.

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

We saw that people had been to visit dentists and opticians to ensure that their sight and oral health were maintained. People were supported by staff to see their GP if they had any concerns with their general health but records did not

Inadequate

Is the service effective?

always detail any follow up action had been taken or that the results from tests had been received and acted upon.

For example, one person had recently had a blood test and staff had not taken action to obtain the results. This put people at risk of not receiving appropriate care and support.

Requires Improvement

Is the service caring?

Our findings

One person told us that the staff were respectful to them and that they could choose how to spend their time. One person said: "I like living here". Another person told us they did not like living here and would like to live somewhere else. Another person told us: "[staff] don't listen to me and shout at me. I hate it and it winds me up". We discussed this with the deputy manager who was to follow this up the provider.

People's dignity was not always respected. One of the staff gave details of a personal nature to another member of staff in front of us and the person whom they were talking about. However, one member of staff spoke with a person asking if it was alright to explain to another member of staff how they liked their care and support needs to be met.

We saw an instance of staff respecting people's privacy and dignity when supporting them. For example there was an incident with a person who used the service and a member of staff quickly took the person up to their bedroom and asked a staff member of the same gender to assist the person. We spoke with two members of staff about how they would respect people's privacy and dignity and both showed a good level of understanding in relation to this.

We observed staff interacting with people who used the service and we saw some positive examples of warm and caring approaches. For example, a member of staff made some comments that the person liked to be nosey and make sure they knew what was going on and keeping managing their behaviours respectfully they responded by smiling, laughing and nodding their head. Most staff talked with the people they were supporting with kindness and warmth.

We saw people were given choices about how they wanted to spend their day One person wished to spend time in their bedroom and we saw that staff supported them to go there and then spent time with them in their room with their chosen activity. Another person chose to sit in the kitchen with staff and have a drink and a snack. People were supported to do the things they wanted to.

Everyone we spoke with had some form of communication aid. Staff were able to explain to us how we could use these when communicating with people. Most staff we spoke with were familiar with people's expressions and gestures and were able to understand people's needs.

Inadequate

Is the service responsive?

Our findings

The information contained in three peoples care plans and risk assessments did not reflect their current needs and had not been regularly reviewed. These care plan's had not been reviewed for 10 months despite people's needs changing. Staff confirmed that not all of the care plans were accurate and that they did not give sufficient information about how people's needs should be met.

We found that where care plans accurately reflected the needs of people they were not always being followed by staff. One person who was being assisted to eat and drink became unhappy and, another member of staff had to take over as they could see they were not being assisted in the way that they preferred. Staff confirmed and records showed that people were not always receiving their planned therapies. The lack of care plan reviews and the lack of all the relevant information placed people at risk of receiving care that was inappropriate or unsafe.

This was a breach of Regulation 9 (1) (a) (b) (i) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People had various communication aids that they had been assessed to use. These included picture boards and light writers. One person did not have their communication aid accessible to them, although when we brought this attention to the staff they immediately rectified this.

People living in the home and staff were not aware of the procedure to follow if they had a complaint. People in the home did tell us that if they had a concern they would speak to a member of staff. Staff were unable to find a copy of the complaints policy and were unsure if there was one. The provider informed us that there was no system in place to record complaints received, investigate them or record their outcomes. They were unable to tell us how many complaints or concerns they have received in the last 12 months and they informed us that only complaints received about staff would be recorded and that this information would be in their personnel file rather than on a complaints log.

This was a breach of Regulation 19 (1) (2) (a) (c) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010**.**

People told us they were supported by staff to take part in activities of their choice, some of these included going out for lunch, hydrotherapy sessions, visits to the local town and cycling. People took part in activities that were important to them.

People told us that they are able to visit their families with support from staff. We were told by the people who live in the home and by staff that families are able to visit anytime.

Inadequate

Is the service well-led?

Our findings

Staff told us there were no formal staff meetings, but a handover was held at the start of each shift. This was to ensure information for the day was given and that any issues or appointments were discussed.

We found there was not an effective system in place to assess and monitor the quality of the service, or to identify, assess and manage risks relating to the health, safety and welfare of people living in the home. The registered manager stated that health, safety or medication audits did not take place. This meant that there was no system in place to ensure people receive safe care.

A member of staff told us that that views of people living in the home, their relatives and staff had been sought via a quality assurance questionnaire in August 2014. However the provider had not formulated an action plan in response to the analysis of the information received in completed questionnaires.

A member of staff told us that on a questionnaire they completed they stated that they would like to talk to the registered manager about the improvements that they thought were needed in the service. However, the registered manager had not arranged a meeting with the member of staff. This showed us that registered manager did not always consider suggestions to improve the service.

People told us that the registered manager spent most of their time at the service in their nearby office and only came into the home every couple of weeks. This meant they were not as aware of the day to day culture of the people or the home they lived in as they could be. Staff felt supported by their peers and they told us that they worked well together. We saw that staff would ask each other for support when needed to ensure people's needs were attended to quickly.

There was a lack of effective systems to identify trends resulting from incidents and safeguarding investigations. For example, the registered manager was unable to inform us about the number and nature of incidents that had happened over the last 12 months because there was no system to bring this information together. This increased the risk of harm to people living at the home.

The registered manager and the provider had not always ensured that notifiable incidents were always reported to the appropriate authorities or that independent investigations were carried out. For example, we noted two safeguarding incidents that had not been reported to the local safeguarding authority and the Care Quality Commission (CQC). We were told that these incidents were being investigated internally which meant information was not shared with agencies involved in the safeguarding of people. The lack of effective reporting mechanisms at the service increased the risk of people suffering harm and that actions to prevent recurrence were not safe or effective.

The registered manager and the provider did not always recognise areas of risk which could result in unsafe care. For example, they had not completed the recommendations following the fire safety officer's report which raised serious concerns and could not give us a clear date when this would be actioned. This meant that the risk of harm to people in the event of a fire was increased.

We also saw that risk assessments did not always identify significant risks to people's health and safety. For example people that were at risk of choking had no risk assessment in place to provide staff with the action to take to minimise the risk.

This was a breach of Regulation 10 (1) (a) (b) 2 (a) (iii) 2 (b) (v) and 2 (c) (i) 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 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People who used services were not protected against the risks of receiving care and treatment that is inappropriate or unsafe by means of the planning and delivery of care and, where appropriate, treatment in such a way as to meet people's individual needs and ensure their welfare and safety. Regulation 9(1)(a)(b)(i)(ii)iii)(iv)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision People who used the service were not protected against the risks associated with an ineffective operation of systems to regularly assess and monitor the quality of the services and to identify, assess and manage risks relating to the health, welfare and safety of people and others who may be at risk from the carrying on of the home. Regulation 10 (1) (a) (b) 2 (a) (iii) 2 (b) (v) and 2 (c) (i).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse People who use the service were not protected against the risk of abuse as staff did not respond appropriately to allegations of abuse. Regulation 11 (1)(b)

Regulated activity	Regulation

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 Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People who use services and others were not protected against the risks associated with the unsafe use and management of medicines by means of making appropriate arrangements for the recording and safe administration of medicines. Regulation 13

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs People were not protected from the risk of adequate nutrition and hydration by means of the provision of a choice of suitable and nutritious food and hydration, and support for the purposes of enabling people to eat and drink for their needs. Regulation 14(1) (a) (b) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers People were not protected as the provider had failed to carry out all the required checks prior to a person commencing their employment. Regulation 21(a) and (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 15 (1) (c)

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 Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements in place for obtaining and acting in accordance with the consent of people using the service, or establishing, and acting in accordance with, the best interests of people using the service. Regulation 18

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints People who use the service could not assured that any complaints would be acted on investigated and resolved to their satisfaction. Regulation 19(1) (2) (a) (c) (d).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The registered person did not have suitable arrangements in place to ensure that staff were appropriately trained to deliver safe care and support to people. Regulation 23 (1)(a)