Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Fisher Close

1-3 Fisher Close, Grangewood, Chesterfield, S40 2UN

Tel: 01246202667

Date of Inspection: 11 December 2013

Date of Publication: February 2014

We inspected the following standards as part of a routine inspection. This is what we found:

Care and welfare of people who use services	✖ Action needed
Meeting nutritional needs	✓ Met this standard
Management of medicines	✓ Met this standard
Staffing	✖ Action needed
Complaints	✓ Met this standard

Details about this location

Registered Provider	Enable Care & Home Support Limited
Overview of the service	Fisher Close is located in Chesterfield, Derbyshire. It offers accommodation for up to 15 adults with a learning disability within three bungalows. It is registered to care for people who need nursing or personal care and it provides nursing care.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 11 December 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

At this inspection there were 14 people using the service. We used a number of different methods to help us understand the experiences of these people because they had complex needs. Most people were not able to tell us their experiences. We observed people's interactions with staff and we spoke with one person and with two people's relatives. We also spoke with four members of staff and read the care plans of three people, to find out more information.

We observed staff interacting positively with people. However, care plans did not always identify risks to people or provide guidelines to staff in managing these risks.

People's relatives told us that people had a choice of food and their special dietary needs were catered for. One relative told us that the food was, "very good." We noted, from reading records and our observations, that people's nutritional needs were being met.

People felt safe and confident with staff administering their medication and said they received their medicines when needed. We found that medicines were being safely stored, administered and recorded.

Relatives felt there were enough staff to meet people's needs. However, one person who used the service disagreed and we found evidence to show that safe staffing levels were not being consistently met.

Relatives told us they knew how to make a complaint. Staff were able to describe how people's changes of behaviour and facial expressions showed if they were unhappy.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 12 March 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

People mainly experienced care and support that met their needs and protected their rights. However, the planning and delivery of care did not always identify risks or show how these should be managed and reviewed. This resulted in undignified practice.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

On the day of this inspection there were 14 people using this service. They had complex needs which meant that most of them were not able to tell us their experiences. We were supported by an Expert by Experience who observed people's interactions with staff and spoke with one person and with some staff. Between us, we spoke with one person who used the service and with two people's relatives about how people were supported at Fisher Close. However, although we spoke to people and their relatives their feedback did not relate to this standard. We also spoke with four members of staff and read the care plans of three people who used the service to find out more information on the quality of service provided.

We found that care was delivered in a way that did not always ensure people's welfare. We observed, on two separate occasions, two staff members removing one person from a lounge area. These actions followed similar incidents when the staff quite clearly felt challenged by the person's behaviour. On one of these occasions we observed staff being impatient with the person. We felt this staff action was undignified for the person concerned and that more appropriate measures could have been available for staff to take. The provider had a clear policy of respecting people's right to receive care with dignity. This action by staff did not follow this policy and we later discussed this matter with the provider.

There were insufficient and inaccurate plans of care in place to meet the welfare needs of this person. We found a care plan that addressed this particular behaviour that challenged staff but there had been no recorded monthly reviews of this plan since December 2011. We read a report, written in August 2011, by a nurse advisor in behaviour management. This report recommended that a meeting be held to decide on what action to take which

would be in the person's best interests. There was no recorded evidence that such a meeting had occurred or that any subsequent action had been taken. The nurse in charge told us they were not aware of a 'best interest' meeting taking place. There were no recorded risk assessments reflecting this particular behaviour and so staff were not being provided with up to date guidance as to how they should appropriately and safely manage this behaviour.

One risk assessment we read related to a different behaviour exhibited by this person: their aggressive behaviour to others. The recorded 'Recommended control measures to eliminate/reduce risk', arising from the person's 'erratic and very unpredictable behaviour' were most unclear. We asked the nurse in charge if they understood the wording and they agreed it was somewhat meaningless. Therefore, staff were not being provided with clear guidance as to how they should safely manage this person's aggressive behaviour to others.

We observed staff interacting positively with people in most situations and talking with them as they provided personal care. In care plan documents we found that staff were encouraged to take an approach to people which was centred on their individual needs and their abilities, rather than disabilities. For example, care plans included statements such as, 'It is difficult to assess my understanding but please assume that I understand everything.' However, we were not sure how far people could understand the pictures in the separate 'Person Centred Plans (PCPs), that were intended to help people understand the contents. Also, there was a lot of handwriting in these PCPs which would likely be inaccessible to most of the people who used the service.

Meeting nutritional needs ✓ Met this standard

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration.

Reasons for our judgement

People were provided with a choice of suitable and nutritious food and drink. The person, and the relatives we spoke with, gave us positive views of the food provided. They confirmed that people had a choice of food and drink and had enough to eat and drink. One relative told us that the food was, "very good…I eat with [my relative] once a week." Our own observations confirmed that the food looked tasty and well presented.

One relative told us that their relative who used the service had special dietary needs and these were fully met by staff. We confirmed this level of knowledge from our discussions with staff.

Two of the three care plans we looked at included details of people's food and drink likes and dislikes. In these care plans we found that staff were encouraged to take an approach to people which was centred on their individual needs. For example, records included 'How you can support me: please read my eating guidelines' and 'What is important to me in the future: to maintain a healthy diet'. All three care plans showed clear guidance for staff regarding people's dietary needs and some of this guidance was based on assessments from a speech and language therapist and a dietician. This guidance addressed some people's swallowing difficulties, risk of choking and need for a soft diet. 'Mealtime Information Sheets' were available for each person who used the service so that staff were aware of individual needs when planning meals. Staff told us that they knew people's food likes and dislikes.

We saw menus displayed in bungalows one and two. The provider should note that these menus did not reflect people's individual food needs and there was no record of alternative meals provided. Also, the menus included no pictures or symbols which would help people to understand them. However, we saw, in bungalow two, pictorial menus that the service was proposing to introduce.

The staff members we spoke with showed a good insight into the nutritional needs of the people who used the service and how these needs were met through, for example, ensuring a suitable consistency of food. We asked staff how they ensured that people's dignity was maintained during mealtimes. Both staff members told us they offered people an apron to protect their clothes.

The provider should note that, according to the two staff members we spoke with, only two staff members had received any training on nutrition. Lack of such training may lead to staff not being fully aware of how to meet people's specialist health needs regarding diet. We were later told by the provider that that two additional staff were booked on nutrition training in January 2014 and additional nutrition courses from the local authority were being sought.

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

The people and relatives we spoke with felt safe and confident with staff administering their medication and told us they received their medicines when they were needed.

All staff who administered medication had been provided with training in the safe use of medicines or they were booked on a course by 17 December 2013.

Care plans provided staff with guidance as to when and how people should be administered medicines that were prescribed 'as needed'. Written protocols addressed the circumstances when these medicines should be administered. They also detailed the amount, and timing, of medicine that could safely be administered in a 24 hour period for individual people. Most of these protocols were up to date but some were being updated.

We looked at three people's medication profiles on care plans. These were centred on people's individual needs and, where necessary, included detailed information about how the person took and swallowed tablets. We looked at three medicine record sheets and these were mostly being recorded in a satisfactory manner. However, the provider should note that we found a lack of countersignatures against several handwritten entries. Two staff signatures against handwritten entries provide a more robust check that the names and dosage of medicines are correct and so reduce preventable drug errors. Sample staff signatures and initials had been recorded so as to provide clear audit trails.

Staff we spoke with described safe administration of medicines and were confident they knew what signs and symptoms to look for with regard to adverse reactions of medication.

Medicines, including controlled drugs, were being safely kept in locked metal cabinets secured to walls. The provider should note that medicines that required to be stored at low temperatures were being kept in a locked box in each bungalow's domestic refrigerator. There should be a separate, secure fridge that is only used for medicines that require cold storage.

Staffing ✖ Action needed

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was not meeting this standard.

The relatives of people who used the service thought there were enough staff to meet people's needs. However, we found there were not enough qualified, skilled and experienced staff to meet people's needs at all times.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

The relatives we spoke with told us they thought there were sufficient staff on duty to meet the needs of their relatives. They felt these staff were competent at their job. One relative told us, "[Staff are] very nice up there."

However, we found evidence that there were not always sufficient, skilled and experienced staff to meet people's needs. We spoke with one person, using the service, who told us they thought there were insufficient staff on duty. We also spoke with four staff members about staffing levels. They all agreed that on the week of this inspection, due to staff sickness, staffing levels had been below normal. One member of staff thought that staffing levels were, "sometimes insufficient but usually OK." Two other staff members said that there were usually two or three shifts a week when each bungalow was staffed by only two support staff. Another member of staff explained there should be three support workers on duty in each bungalow and a trained member of nursing staff. This staff member told us that one nurse on duty per bungalow, "seldom happens." They felt that only two members of nursing staff, across the three bungalows may be "unsafe" when, for example, someone has a severe seizure.

On the day of this inspection, there were only two members of support staff on duty in each bungalow during the afternoon shift. The duty rota showed that, on the previous day, there had only been two members of support staff on duty throughout the day in one of the bungalows. During the incident we observed - recorded earlier in this report - we considered that the support staff appeared stressed. At that time there was only one nurse on duty for the three bungalows.

Staff told us that the people using the service were dependent on staff who could drive the service's mini-bus for taking them out. They said there was a lack of drivers and, in one bungalow, there were, "no drivers for the majority of the time." We confirmed this from the duty rota. Staff said that this lack of drivers meant that people's social needs may not be met and there were less opportunities for staff to divert people's attention, through a trip

out, when their behaviour was challenging staff.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments people made were responded to appropriately.

Reasons for our judgement

People were given support by the provider to make a comment or complaint where they needed assistance. The person we spoke with told us they had seen, and understood, the provider's complaints procedure. They told us that the provider responded to complaints, though they were not always happy with the outcome.

The two relatives we spoke with both told us they knew how to make a complaint, though only one had seen a copy of the provider's complaints procedure. Although the other relative said they had not seen a copy of this procedure they had made one complaint and this had been handled to their satisfaction.

In one of the bungalows we saw a copy of the provider's complaints procedure leaflet which was in an 'easy to read' form. We asked two members of staff, in two separate bungalows, if the people who used the service had access to this leaflet. The provider should note that one staff member could not find a copy of this leaflet and the other staff member had not seen it. Staff in one bungalow told us that the people who used the service could not understand the complaints leaflet. Staff in another bungalow said that the people they supported could not communicate. These comments indicate that the complaints procedure leaflet may not be understandable to all the people who used this service. The leaflet may therefore not provide a means of support to all the people who may be unhappy with the service.

Staff we spoke with were able to describe how the people who used the service can make a complaint indirectly, through staff observing changes in their behaviour and acting on their behalf. They gave examples of people feeling unhappy which may be displayed through facial expressions, gesturing or refusing to eat or drink.

Advocates were available to the people who used the service, to support them in important life decisions, but not all of the staff we spoke with were aware of this resource.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The provider had not taken proper steps to reduce the risk of people receiving inappropriate care through planning and delivering care to ensure their welfare and safety. Regulation 9(1)(b)(ii)
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: The provider had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff in order to safeguard people's health, safety and welfare. Regulation 22

This section is primarily information for the provider

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 12 March 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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