London Residential Healthcare Limited

Chestnut House Nursing Home

Inspection report

Chestnut Road
Charlton Down
Dorchester
Dorset
DT2 9FN

Tel: 01305257254
Website: www.lrh-homes.com

Date of inspection visit:
13 January 2022
14 January 2022
17 January 2022

Date of publication:
18 March 2022

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Chestnut House Nursing Home is a care home providing personal and nursing care for up to 85 people. At the time of the inspection there were thirteen people living at the service, some of whom were older people living with dementia. People were all accommodated on the ground floor of the home.

People's experience of using this service and what we found
The provider's governance systems had not ensured that actions were taken in response to environmental shortfalls. We found no evidence people had been harmed but these shortfalls placed people at risk of harm or injury. They were identified in both the provider's own audits and our last inspection report. We made a referral to the fire service who arranged a fire safety inspection visit. They identified there were actions that were needed to ensure the fire safety of the service and these works were required to be addressed within two months.

People felt safe and were comfortable and relaxed with staff who supported them. Relatives told us they felt their family members were safe and very well cared for. Throughout the inspection we saw kind and caring interactions between people and staff.

There were enough staff to meet people's needs and there was a stable staff team who knew people well.

Risks to people were identified and recorded, and staff knew how to respond to these risks in order to keep people safe. Medicines were managed safely and effectively by staff who were trained and competent to do so. A consistent system was not used to record people's as needed medicines. The provider agreed to ensure this was implemented.

Risks relating to infection prevention and control (IPC), including in relation to the COVID-19 pandemic were assessed and managed. Overall, staff followed recommended IPC practices. Safe visiting was supported.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People benefited from a manager, deputy manager and staff team who promoted a positive culture. They focused on people being treated as individuals and staff had continued to make improvements in the personalised care that people received. Relatives spoke highly of the manager and staff and the communication between them.

Rating at last inspection
The last rating for this service was requires improvement (published 5 August 2021) .The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the provider remained in breach of one regulation.

The service remains rated requires improvement. This service has been rated inadequate or requires improvement for the last seven consecutive inspections since 2017.

Why we inspected
We undertook this focused inspection as part of our public commitment to rerate services. This was to release capacity in the adult social care sector during the pandemic. This report only covers our findings in relation to the Key Questions Safe, Caring and Well-led.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively. This included checking the provider was meeting COVID-19 vaccination requirements.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led sections of this report.

The provider has taken action to mitigate the risks identified and has worked with the fire service to ensure people's safety.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained Requires Improvement. This is based on the findings at this inspection.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We have identified a repeated breach of regulations in relation to the provider's oversight and not acting in response to their own and CQC's previous findings in relation to fire safety issues and hot water temperatures.

We have issued a warning notice that the provider must be compliant with the regulations by 1 April 2022.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service caring? The service was caring. Details are in our caring findings below.	**Good**
Is the service well-led? The service was not always well-led. Details are in our well-Led findings below.	**Requires Improvement**

Chestnut House Nursing Home

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of two inspectors.

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

The service did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided. At this inspection the manager had cancelled their registration as they were retiring. A new manager had been appointed and was due to start at the service in February 2022.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection, including the provider's action plan. We received feedback from the local authority and commissioners who work with the service. We used all of this information to plan our inspection.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We met with all of the people living at the service, spoke with four people in detail and four visiting relatives. Not all people could speak with us about their experience of living at the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with eight staff including the manager, deputy manager, care staff, an agency nurse, the activities co-ordinator and maintenance person. We held a video conference with the manager, nominated individual and two of the provider's quality assurance and governance team. This was to discuss the governance arrangements at the service.

We reviewed a range of records. This included three people's care records and five people's medication records. We looked at a variety of records relating to the oversight and management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found and receive updates as to actions taken. We looked at training data, policies and quality assurance records. We sought feedback from professionals who work with the service and received feedback from one. We received feedback from one relative in response to the inspection poster displayed in the service.

We continued to review the information we received from the service and feedback from relatives and professionals until 28 January 2022.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

At the last inspection, risks to people's health and safety were not monitored and mitigated by the governance systems in place.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The provider carried out risk assessments and regular health and safety checks. The audits and safety checks continued to identify the risks identified with the faulty fire doors and hot water systems. However, actions had not been taken to address these sufficiently. At the time of the inspection the work required to the hot water systems were in progress. However, there had been no progress by the provider in addressing the shortfalls in the faulty fire doors at the service that were initially identified in March 2021 and again at our inspection in June 2021.
● There was no evidence of harm experienced by the people at the service as a result of the shortfalls identified. However, the risk remained, and we made a referral to the fire service who arranged a fire safety inspection visit. The fire service identified there were actions that were needed to ensure the fire safety of the service and these works were required to be addressed within two months.

The provider's governance systems had not mitigated the risks to the health, safety of people using the service. This placed people at risk of harm and injury. This was a continued breach of regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. The work required to address the risks from hot water were completed in the areas that accommodated people. They provided us with confirmation of updated fire risk assessments and updated the overall evacuation plans for the people accommodated in the home. This was whilst they were waiting for the full assessment of fire safety from the fire service and subsequent repairing and or replacement of faulty fire doors. The actions taken addressed the immediate risks to people.

● People had risk assessments and associated care plans in place. Assessments were carried out to identify risks to people's health and safety and care plans were in place detailing how these could be reduced. These

were completed for issues such as risk of falls, choking, moving and handling, nutrition, and skin integrity.
● Care plans were developed following these assessments to help prevent or minimise the risk of harm to people using the service.
● People told us the staff were skilled at supporting them in ways that helped them stay safe. One person commented on how good the staff were with their mobility equipment. We observed staff supporting people to move safely in ways described in their care plans.
● Staff understood the risks people faced. They were able to describe the measures in place to support them with confidence. This included risks related to eating and drinking safely, physical and mental health related risks, risks associated with going out and those associated with isolation.
● The risks people faced and the measures in place to support them were reviewed regularly.

Using medicines safely
● People received their medicines safely from staff who had received medicines training. This included specific training, and competency checks.
● People told us that staff supported them to take their medicines safely. One person told us, "They are good with meds."
● People told us they had access to pain relief when they needed it. One person told us, "I can ask for paracetamol, if I am in pain."
● Medicines management was audited regularly with systems in place for investigating any potential medicines errors.
● Some people were prescribed medicines on an 'as and when required' basis (PRN), for example for pain management. The service had protocols which provided staff with information about when these medicines should be given. There was not a consistent system for recording PRN medicines, and this was an area for improvement. The provider agreed to ensure this was implemented.

Systems and processes to safeguard people from the risk of abuse
● People looked very comfortable and relaxed with the staff who supported them. People said they felt safe and staff treated them with kindness. Relatives also told us they felt their family members were safe. One relative said, "She's very safe and I don't worry about her when I leave."
● There were safeguarding and whistle blowing policies in place and staff understood their role when reporting potential abuse or harm.
● Staff had completed safeguarding training. Staff we spoke with understood how to identify and report safeguarding concerns.

Staffing and recruitment
● There were enough suitably skilled and experienced staff on duty to meet the needs of people currently living at the service. There was an ongoing recruitment campaign at the service.
● People told us they did not usually have to wait if they needed the staff for support. One person told us: "They mostly do alright for staff." People said that they did sometimes have to wait but this did not happen very often.
● Two relatives told us it sometimes felt that there were less staff on duty at the weekends and they sometimes had to wait to be let in. Records showed and the manager confirmed that staffing levels were the same. The manager acknowledged as there was not any administration or manager on duty at the weekend this may contribute to delays in visitors being let into the home.
● Call bell times indicated that people did not have to wait long to be attended to but there was evidence of times when it appeared staff were being called repeatedly. This suggested the staff were silencing the alarm but letting the person know they could not help them at this point. Two people commented that these bells had an impact on their ability to sleep and disturbed their peace. We discussed this with the manager who

told us they would seek to reduce the volume of the bells especially at night.
● There had not been any new staff recruited since the last inspection, so we did not check recruitment procedures. Agency nursing staff were used and information about the suitability and training of these staff was held at the service.

Preventing and controlling infection
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely. Most people told us that staff wore their PPE appropriately, one person said they could not always be sure about this and we observed that staff needed prompting to wear their masks on one occasion. The manager took immediate action and reminded all staff about PPE use and good hand hygiene. IPC refresher training was booked for the week following the inspection.
● We were assured that the provider was accessing testing for people using the service and staff. The manager was working to ensure all essential care givers were taking part in the home testing programme.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Care home visiting
● The provider was facilitating visits for people living in the home in accordance with the current guidance. Essential visitors had been identified for people and confirmed they had continued to visit their family member at the home at all times.

Care homes (Vaccinations as Condition of Deployment)
● From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement. The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

Learning lessons when things go wrong
● Safeguarding, accidents and incidents were recorded and investigated and where appropriate, measures were put in place to mitigate the risk of reoccurrence. Lessons learned were shared with staff at handovers, meetings and supervisions. For example, historically only nursing staff contacted and updated relatives. Following concerns being raised, now all staff could phone people's relatives to make sure they are kept informed about important changes.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection when this key question was rated, we rated it requires improvement. At this inspection the rating has changed to good.

Ensuring people are well treated and supported; respecting equality and diversity

- People told us they were treated with kindness and compassion. One person told us: "The staff are friendly, patient, kind and funny." Another person commented: "I would recommend it here. It is a lovely place to be and they have been good to me." A relative said, "I would give it 10 out of 10, I can't fault it. We're very happy with everything since Mum has been here. Mum always looks comfy and well cared for."
- Staff were kind in all their interactions with people. They were quick to provide support when people were distressed and understood the details that mattered to people. One person said, "Nothing is ever too much trouble."
- Staff reflected on how they ensured people received care and support in ways that was personalised to them. They also described how the respect and care extended to all staff. One member of staff commented: "It is a very caring, considerate home. Staff are welcomed. People are welcomed."

Supporting people to express their views and be involved in making decisions about their care

- People described living their life the way they chose to and making day to day decisions. One person described how they liked to stay in their room and that this was respected. Another person described how staff had responded to feedback and now always provided them immediate support if an alarm sounded.
- People's care was delivered in a way that reflected their preferences and wishes. Care plans detailed this information and staff understood it. For example, where people liked time outside this was reflected in the care plans and enabled by staff.

Respecting and promoting people's privacy, dignity and independence

- People's privacy was respected. For example, one person did not like to be disturbed in their bedroom and their care plan was clear about this. We also observed people were afforded space to speak to relatives and professionals in private.
- People told us they were supported in ways that promoted their independence and maintained their dignity. One person reflected on how kind the staff were when they supported them with personal care tasks; noting they never made this seem difficult. Care plans were clear about the support people needed so that staff did not provide unwanted help.
- A relative fed back via our website, 'The staff are dedicated, kind, caring and respectful of the residents' dignity.'

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

At our last inspection the provider had failed to ensure that oversight was effective in improving the health, safety and welfare of people. It was considered that not enough improvement had been made in relation to the governance of the service and the provider was still in breach of the regulation.

Despite the assurances previously given by the provider, not enough improvement had been made at this inspection and the provider was still in breach of regulation 17. The service has not been compliant with this regulation since 2017.

● CQC has previously taken enforcement action and imposed and varied conditions of registration on the provider. At the last inspection significant improvements had been made and it was considered these conditions of registration were met. The provider gave us assurances that actions would be taken in response to the findings of the inspection in June 2021 in relation to the fire doors and hot water systems. These agreed actions were not completed.
● There were regular audits and governance arrangements in place completed by staff at the home and provider. There was a service improvement plan in place and actions had been taken to address the areas the manager was responsible for. However, the systems had not escalated , to the provider's responsible persons, the shortfalls identified in their own audits or the requirements of CQC to ensure the safety of people living at Chestnut House Nursing Home.

The provider's governance systems had not effectively mitigated the risks to the health, safety of people using the service. This placed people at risk of harm or injury. This was a continued breach of regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the last inspection, the manager registered with CQC. At this inspection the manager had cancelled their registration as they were retiring. A new manager had been appointed and was due to start at the service in February 2022. The retiring manager planned to work alongside the new manager to make sure there was period of handover.
● There had also been changes in the nominated individual, senior and governance managers for the

provider since the last inspection. The new nominated individual was proactive in taking action to ensure the safety of people at the service.

● The manager used the outcome of audits to improve people's experiences. For example, following a mealtime audit, people chose the décor in the dining area and the ambient music that was played during mealtimes. People told the manager that following the changes their mealtimes felt more like being at home when they listened to the radio.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People benefited from a manager, deputy manager and staff team who promoted a positive culture. They focused on people being treated as individuals and staff had continued to make improvements in the personalised care that people received.

● People's preferences were known by staff and the daily care and support reflected these. This was an improvement to previous inspections. The care and support were personalised and responsive rather than being task focused. People were actively engaged in lots of different activities to keep them occupied either individually with staff or in small groups. For example, staff sang and danced with people to their favourite songs and styles of music.

● People told us they had not been formally asked if the support and care they received was as they wished it to be. They told us they were able to speak with staff but said they would like to be asked for their feedback. One person gave the example that they would tell the manager about the noise of the call bells. The manager and provider agreed to include this as part of people's individual reviews.

● Relatives spoke highly of the manager and staff and the communication between them. They said they with involved in their family member's care and were kept up to date with important matters. One relative fed back, 'I am kept informed of any changes in my husband's care and he seems content and happy.'

● Staff morale was good which led to a happy environment for people to live in. Staff said that communication had improved. There were regular staff meetings and daily handovers.

● Staff were proud of the teamwork and showed they genuinely cared for people living at Chestnut House Nursing Home.

● Staff felt well supported by their colleagues, the management team and provider. They felt their work during the pandemic had been recognised and their well-being was supported.

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

● The manager understood their responsibilities to be open, honest and apologised if things went wrong. There had been no complaints received since the last inspection.

● The registered manager made sure we received notifications about important events so we could check appropriate action had been taken.

● Information was appropriately shared with the local authority safeguarding team and CQC. We identified that a medicines error had not been notified to the local authority under local safeguarding reporting arrangements. The manager agreed to notify the local authority.

● The rating from the last inspection was displayed at the service and on the provider's website.

Working in partnership with others

● The service worked closely with other health and social care professionals to ensure people received consistent and timely care. People's care records detailed the involvement of family members, specialist nurses, GP and district nurses. A health professional confirmed that staff at the home sought advice when needed and referred people for medical attention appropriately.