Chilton Care Homes Ltd

Chilton Croft Nursing Home

Inspection report

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Ratings

Is the service caring?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 09 and 10 October 2014. We completed a follow up inspection on 19 February 2015. After these inspections we received concerns in relation to a visiting health professional who had concerns about end of life care. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Chilton Croft nursing Home on our website at www.cqc.org.uk

Chilton Croft Nursing Home is registered for 32 people who require 24 hour nursing support and care. Some people who use the service also have a physical impairment and or living with dementia. This service requires a registered manager.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager of the service was not there on the day of the inspection, but the clinical lead nurse was present.

The report specifically focuses on the aspect of the key area of 'Caring'. This included end of life care and arrangements for expected and unexpected deaths within the service.

We found some good aspects of care with people telling us they were well cared for. We found that people were respected and their wishes were documented. People and their families were involved in the care planning process.

The arrangements for end of life care were not well developed. Plans were in place, but as yet had to come to full fruition. Equipment held to use in an emergency and end of life were not checked, readily available and fit for purpose. Out of date equipment was in place. We had not been accurately notified of a death within the home. This meant the provider was not meeting the requirements of the law.

Summary of findings

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 caring?

The service was inconsistently caring.

Positive, caring relationships had been formed between people and staff. People were looked after by staff that treated them with kindness and respect.

People were involved in decisions about their care and support, but were exposed to potential risks through equipment not being checked as fit for purpose. End of life care was not thoroughly developed.

Requires improvement

Chilton Croft Nursing 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.

This responsive inspection took place on 02 November 2015 and was unannounced.

The membership of the inspection team included an Inspector and a Specialist adviser. Our adviser was a specialist nurse in end of life care.

Information was gathered and reviewed before the inspection. This included all the information we held about this provider, including statutory notifications. These are events that the care home is required by law to tell us about. Including the circumstances around people's death.

The methods that were used included talking to two people using the service, three of their relatives and friends, speaking with four staff, examining the care records of ten people, and observation of care. We also looked at and reviewed records relating to notifications, training, and management of the service.

Requires improvement

Is the service caring?

Our findings

We carried out this inspection in response to concerns which had been raised by a health professional that a person who unexpectedly died at the service may not have had timely care and treatment as needed. We completed fact finding around this case. Looked at lessons learnt and changes made within the service and examined the experience and procedures currently in place for people since the event some four weeks previous.

Where appropriate people's care folders contained an inner yellow plastic wallet that held Advance Care Planning discussion records and completed DNACPR (Do not attempt cardiac pulmonary resuscitation) forms. We found that these documents were appropriately signed and dated. In one case these were signed by the individual themselves. Two people's files indicated that they wished to be resuscitated. Staff spoken with were aware of who these two people were and had recent training to teach them the skill of resuscitation. In the nurses office there was a list of people who wished to be resuscitated and those which did not, in line with the care plans and wishes stated in them, however this was confusing and staff would not always be able to be clear on people's wishes according to this list. This was brought to the attention of the clinical lead who agreed it could be confusing and agreed to amend the form so instruction was clear.

We found that lessons learnt from the incident were not well developed. The death had been recorded as an expected death, when in fact the death had been unexpected and incorrectly recorded. Guidance for staff on expected and unexpected deaths was being revised and a timescale of December 2015 was agreed upon on the day of our visit. The policy for DNACPR for the home has not been updated since the emergency incident. A privacy screen had been ordered for the main lounge area. Additional training by the clinical lead was planned, but this person had yet to obtain their training dates to then cascade to other staff. The clinical lead told us that an emergency bag had been developed with equipment for nurses to access to help treat emergencies. However, when we asked to see this we found this was not in place. A bag was on order. Suction equipment was kept in a locked room and the key was held by the nurse and so not easily accessible to all staff. The suction machine was in a clear plastic bag, the suction tubing required for it was in a separate clear plastic bag. Nothing was labelled and suction tubing was out of date. The specific suction tube mentioned by the clinical lead was not available as suggested by them.

We also looked at equipment that would be used to deliver instant relief pain medication to people at the end of life. This would be through a piece of equipment called a syringe driver. The instructions to use this piece of equipment were kept separately in an office. In the syringe driver box were out of date and opened non sterile pieces of equipment. The box was dirty and had dust and debris in the bottom. The lead nurse confirmed that this equipment and the suction machine was not checked monthly to ensure everything was in working order and in date. Also in the box was an old style Graseby syringe driver that was not used anymore. If a person were to need immediate use of life saving or pain relief equipment it would not necessarily be readily available and fit for purpose.

This was a breach of the Regulations 12(2) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3).

The registered persons are required to notify us about deaths within the service without delay. We had received a notification about an incident, but the information sent to us was incorrect. We were given a different copy with contradictory information on it during our inspection. The incorrect information misled the Commission into believing that the person was expected to die when in fact this was unexpected. We will continue to monitor future notifications.

People experienced positive caring relationships with staff who supported them. One person said, "All the staff are lovely. I feel fortunate to be here." A relative said, We know who the manager is and think he is a brilliant guy. [Staff named] is the keyworker and she is particularly caring and helpful." There was a noticeboard inside the reception area with staff photographs and names so people could identify who was who within the service. This included the management team who people knew and said they were visible and available to them.

People had their privacy and dignity maintained. One person told us, "Yes they always knock on the door and ask permission before coming in or helping me." We observed staff knocking on people's bedroom doors before entering and they place a sign on the door 'personal care being

Requires improvement

Is the service caring?

given' when appropriate. We also observed two staff hoist a person in the main lounge. They did this in such a way as to maintain the person's dignity and they explained what was happening and sought consent. We heard a bell call and staff immediately responded to the persons need for support to use the toilet.

We asked a person if they felt they and people at the home received individualised care. The person said. "Yes the care is individualised. I am comfortable enough here." Their relative gave an example of how they had brought in a favoured food and staff had prepared this, but the chef had then ordered this in at the home for the person as they liked it. A different relative told us how the staff had given individualised care by ensuring their relative had their hair care as preferred.

People were able to express their views and were involved with their care. A relative gave an example of how they felt the manager had been, "Understanding and observant" of their relative. Their relative liked a china cup to drink from and they had brought one in. The manager had responded positively and agreed to purchase more similar style cups for people as they thought this was a good idea. A relative spoke about a monthly resident and relative meeting they had been invited to. They had a suggestion to make and planned to attend and felt that they would be welcomed and listened to by the management within the home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Life saving and end of life equipment was not regularly maintained and fit for purpose. This posed a risk to peoples health and well being.**