

Chantry Retirement Homes Limited

Euroclydon Nursing Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Euroclydon Nursing Home is a residential care home providing accommodation to persons who require nursing or personal care, to up to 48 people. The service provides support to older people and people living with dementia. At the time of our inspection there were 30 people using the service. People are accommodated in one adapted building.

People's experience of using this service and what we found

The manager and provider had implemented new quality assurance and monitoring systems to improve the outcomes for people at Euroclydon Nursing Home. However, these systems were not fully embedded and were therefore not fully effective at addressing the shortfalls we identified on inspection. More time was needed to allow whole service improvement and sustained good outcomes for people.

People's care records were not always current and reflective of their needs. The manager was aware of this shortfall and taking action to improve people's care records and outcomes.

People did not always receive care which was personalised to their needs and promoted their wellbeing.

Measures were in place to make improvements and ensure people received person-centred care. More time was needed to allow the improvements to be implemented and maintained.

Risks relating to the environment were now assessed. However, the manager was further developing a system to oversee recruitment and legionella risk management, where shortfalls were found. We have made recommendations about the management of both recruitment and legionella.

Staff supported people in the least restrictive way possible and in their best interests. Where people were living under Deprivation of Liberty Safeguards; staff understood the support they required.

Since our last inspection, the registered manager and provider had ensured records in relation to people's mental capacity had been reviewed.

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.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update

The last rating for this service was requires improvement (published 22 August 2022).

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 improvements had been made, however the provider was still in breach of the regulations.

Why we inspected

We carried out an unannounced comprehensive inspection of this service on 13 April 2022. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance.

We undertook this focused inspection to check whether the Warning Notices we previously served in relation to Regulation 17, and a requirement notice in relation to Regulation 12 and Regulation 18 Care Quality Commission (Registration) Regulations 2009, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. We also received information of concern in relation to people's personal care since our last inspection.

This report only covers our findings in relation to the Key Questions Safe, Responsive and Well-led which contain those requirements.

For the key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service remains requires improvement. This is based on the findings of this inspection.

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

Enforcement and Recommendations

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 will continue to monitor the service and will take further action if needed.

We have identified a breach in relation to person centred care and records in responsive, and a continued breach in relation to good governance, at this inspection.

Please see the action we have told the provider to take at the end of this report.

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 responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Euroclydon 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 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 was carried out by two Inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

Euroclydon Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Euroclydon Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there wasn't a registered manager in post. There was a manager who planned to register with CQC, however at the time of our inspection hadn't started the registration process.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We used the information the provider sent us in their latest provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection. We reviewed information and feedback we had received from local authority commissioners in relation to Euroclydon Nursing Home. We used all this information to plan our inspection.

During the inspection

We spoke with 12 staff including the manager, deputy manager, 2 nurses, 2 senior care staff, the head housekeeper, maintenance lead, activities co-ordinator and 3 care staff. We also spoke with 9 people living at Euroclydon Nursing Home and with 9 people's relatives.

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 reviewed a range of records. This included 5 people's care records and multiple medication records. We looked at 4 staff files in relation to recruitment and supervision. A variety of records relating to the management of the service, including governance systems, policies and procedures were reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at policies and procedures and quality assurance records. We gathered feedback from 2 professionals who visit the service.



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 for this key question remains the same. 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.

At our last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. People had not always been protected from the risks associated with their environment. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12. However further improvements were required, and we have made recommendations to the provider.

Assessing risk, safety monitoring and management

- Service users were now protected from the risks of their environment. However, further consistency was required in relation to monitoring risks within the home. A maintenance worker had recently been employed and carried out water temperature checks. These checks had not always identified out of range temperatures in a timely manner. We discussed this concern with the manager who was developing the system to ensure any risks were identified and acted upon swiftly.

We recommend the provider review the implementation of their legionella risk assessment to ensure they have the required risk mitigation measures in place.

- People's risks were assessed and known by care and nursing staff. One person had been assessed as 'high' risk of skin damage. Nursing and care staff were aware of the person's needs and the support they required. Nursing staff kept a record of the support provided.
- One person was living with diabetes. The person had a clear care plan which nursing and care staff followed. Nursing staff kept a record of the person's blood sugar levels. Staff sought the advice of healthcare professionals and worked with the person to help maintain their health and wellbeing.
- Since our last inspection, the provider had ensured everyone living at Euroclydon Nursing Home had a Personalised Emergency Evacuation Plan (PEEP). These provided clear guidance for staff to follow to assist people to evacuate or stay safe in the event of a fire.

Staffing and recruitment

- Appropriate recruitment checks had not always been fully documented prior to staff starting work. Reference checks from staff's previous social care employers had been sought to gather assurances around staff conduct however there was not always a clear record of this.
- We recommend the provider, review their recruitment processes and documentation to ensure they have

the appropriate records.

- Suitable staffing levels were in place to meet the needs of people using the service. Since our last inspection the manager had reviewed staffing levels and made changes to ensure people's needs were met. This included increasing nursing and care hours at key times.
- People and their relatives told us there were enough staff to meet their loved ones needs. People and staff spoke positively about staffing, including the reduction of agency. One person told us, "If I need anyone, there is always a person available."
- Staff told us there were enough staff and they had the time they needed to provide people's care. Comments included; "We have enough staff now, it has definitely improved" and "We have more staff now. We also have senior care staff who are trained to administer medicines. This really helps."
- Staff were recruited safely. All required checks were made before new staff began working at the home. Disclosure and Barring Service (DBS) checks were completed alongside seeking references from staff's previous employers. These checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely

- Systems had been implemented to reduce risks associated with the unsafe medicines management. While improvements had been made, these systems had not been fully implemented. Two people had been placed at risk of not receiving their medicines as prescribed. However, their health or wellbeing had not been impacted and the manager took immediate action to strengthen the system.
- The provider and manager ensured procedures were in place for the safe and effective storage of medicines. Staff had not always returned the stock of medicines when people's prescribed medicines had been discontinued. We raised this concern with the manager who took effective action.
- Some people were prescribed medicines that were to be administered 'as required' when they could be anxious or distressed or were in pain. Since our last inspection the management had reviewed and updated people's 'as required' protocols. These contained clear guidance for staff to follow, including when to administer these medicines and how to review the effectiveness of their prescribed medicines.

Learning lessons when things go wrong

- Since our last inspection the manager and provider had taken action to improve the quality of service people received living at Euroclydon Nursing Home. They had identified where things had gone wrong and implemented action plans. This included supporting staff to develop and work alongside nursing staff to help drive the quality of people's care.
- The management had identified concerns in relation to the effectiveness of staffs' contact with healthcare professionals, which had affected people's prescribed medicines and associated records. They were working to improve these working relationships, which included formalising a weekly GP round with nursing staff and staff from the GP surgery.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- 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.
- We were assured that the provider was accessing testing for people using the service and staff.
- 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.

Visiting in care homes

The provider was following current government guidance in relation to visiting at the time of the inspection.

Systems and processes to safeguard people from the risk of abuse

- People and their relatives told us they felt the home was safe. Comments included: "I'm very pleased with the home, the staff are so good, he is safe" and "I think that he is safe."
- The manager and deputy manager were visible and regularly worked alongside staff and met people's visitors which made it easier for any concerns to be identified or reported'
- Staff had read the provider's whistleblowing policy and procedures and felt able to report any concerns about poor practice or inappropriate staff behaviour. One member of staff told us, "I would speak to [manager]. I don't have any concerns, things are improving."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People did not always benefit from effective engagement and activities which reflected their needs and preferences. While the home provided some activities, we observed there were limited group activities tailored to people and their interests. One person told us, "There's nothing to do here so I can get bored." A relative commented, "[people] just sit in front of the telly." The manager and activities co-ordinator had identified this prior to our inspection and had implemented an action plan to make the necessary improvements.
- People's care notes provided limited evidence of activities or engagement carried out by staff. For example, three people's ongoing notes provided limited record of activities, recording only hairdressing and discussion.
- People's relatives told us they were not aware or involved with people's care plans. Comments included, "I don't know anything about a care plan" and "I've not seen or been involved with a care plan."
- People's care plans did not always support person centred care as they were not an accurate reflection of people's needs or preferences. There were not always care plans in place based on their personal needs, and some records were incomplete or missing.
- One person's care plan did not detail their full preferences and the support they received from staff. We observed staff assisting this person with choice and reassuring them when they were anxious. The person's care plan did not reflect the support provided by staff including different techniques and options staff could take.

People did not always receive care which was personalised to their needs and promoted their wellbeing. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager was aware of our concerns and was taking action to ensure people's care plans were current and person centred. They also had plans in place to improve the activities and engagement people received at Euroclydon.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in

relation to communication.

- People's communication needs were identified, assessed and recorded in care plans. They referred to how people communicated their needs and any support they required. One person was registered blind and there were clear guidelines for staff to follow to communicate with them and promote their independence.

Improving care quality in response to complaints or concerns

- People and their relatives told us they knew how to make a complaint to the service. Comments included, "If I had a complaint I would speak to the manager" and "If I had a complaint I would go to (home administrator)."
- The manager kept a record of complaints and concerns they had received. One concern had been received since the last inspection. The manager had fully investigated the complaint and implemented changes. This included increased monitoring of the area of concern. The concerned party was happy with the response.

End of life care and support

- People were cared for at the end of their life through the service working in partnership with health professionals. Staff spoke positively about end of life care and ensured people received the care and support that was important to them, including being visited by their loved ones.
- Where able to do so, people had recorded their wishes for their end of life care and these were known to the staff. One person had clearly documented their views on the end of their life and the medical support they required. The management team had identified there were improvements needed to ensure everyone's views and personal preferences regarding end of life care, were identified and recorded. Including where appropriate, those of people's relatives.
- The service worked with healthcare professionals to ensure people were comfortable at the end of their life. Where relevant, anticipatory medicines had been prescribed by people's healthcare professionals.

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 the same. 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.

At our last inspection systems to assess, monitor and mitigate risks to the health, safety and welfare of people using the service were not operated effectively. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had also not notified the commission without delay of incidents which had occurred, and which had involved people whilst services were being provided to them. This was a breach of regulation 18 (1) of the Care Quality Commission (Registration) Regulations 2009.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009. However, not enough improvement had been made at this inspection and the provider was still in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- At the time of our inspection there was not a registered manager in post. Euroclydon Nursing Home requires a registered manager as part of the provider's registration with CQC. A manager had been in post since the last registered manager left in May 2022, however they had not started the process to register with CQC. The manager told us they intended to start the registration process following this inspection.
- Since our last inspection the manager and provider had implemented new systems to monitor the quality of the service they provided at Euroclydon Nursing Home. Whilst improvements had been made, the manager and provider were aware that further improvements were required. The manager was aware of the majority of shortfalls we identified at this inspection in relation to people's care plans and the provision of activities. However, more time was needed for some actions to be completed and embedded before we could judge that the provider's actions had been effective in making and sustaining improvement. For example, the provider's audits had not identified the concerns we found in relation to water temperature monitoring and recruitment.
- Some care records and documents were not complete, current or accurate to clarify and reduce associated risks to people. For example, records relating to one person's behaviours of concern had not been recorded to guide staff to provide consistent support.

Quality assurance and monitoring systems were not fully embedded and were not fully effective at addressing the shortfalls we identified on inspection. People's care assessments were not always current, contemporaneous or reflective of people's needs. While this placed people at risk of harm, people had not

been impacted by these shortfalls. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager had identified improvements were required in relation to staffing and staff skills. They had taken action to provide training and support to staff. This included identifying and supporting new senior care staff. Senior care staff had also received additional training to enable them to lead teams and assist nursing staff. One nurse told us, "This has really helped. They are very strong carers and it's improved leadership and culture in the home."
- We observed the manager led by example and was visible throughout the home. A staff member told us, "The manager is amazing and working really hard to turn things around." The manager was now working to engage further with relatives to ensure they also had a point of contact to raise any concerns and share any feedback.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- We observed at times there was a lack of engagement and activities which impacted upon person centred care. However, art activities were already taking place routinely for some people, and the manager and activities co-ordinator had implemented an action plan and were working towards improved outcomes for all people living at the home.
- The manager received positive feedback from staff, people and professionals. People told us that despite the challenges faced by the service, the manager was hard working and dedicated to achieving good outcomes for people. One person said, "The manager is very friendly and approachable. The [people] seem to be drawn to her and she's always positive." One person said, "I'm very appreciative of what [the manager] is trying to do."

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 requirements in relation to duty of candour and had an open and honest approach.
- The provider displayed their Care Quality Commission (CQC) rating within the service and on their website.
- People and their relatives told us they would complain to the staff or the manager if they were unhappy about their care. People knew who the manager was and how to complain. The manager was developing their relationship with relatives so they also felt confident with raising issues and concerns with them.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Surveys and meetings were not consistently carried out by the provider to gain feedback from people, relatives and professionals so they could be assured people's needs were met. Resident meetings and relatives' meetings had not been taking place routinely. This meant people and their relatives also did not have a formal opportunity to share their views of the service to influence change. The manager told us they planned to introduce these as part of the development of the service.
- The manager told us they intended to further improve engagement with family and friends of people they support by introducing a monthly newsletter to be shared in hard copy and electronically.
- The service worked in partnership with health and social care professionals to ensure people received the best possible outcomes.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	People did not always benefit from effective engagement and stimulation. People's care plans weren't always person centred. Regulation 9

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	People's care assessments were not always current, contemporaneous or reflective of people's needs. Regulation 17.