Benslow Management Company Limited

Chiltern View

Inspection report

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Date of inspection visit:
12 December 2022
10 January 2023

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22 December 2023

Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

Chiltern View is a residential care home providing personal care to up to 36 people. The service provides support to older people and people who have dementia. At the time of our inspection there were 19 people using the service.

The premises are on three levels with bedrooms on the first and second floors. On the ground floor there are further bedrooms and communal areas including a lounge, dining area and conservatory. There is also shared garden space. Administrative and management offices are also on the ground floor.

People's experience of using this service and what we found
People's medicines were not managed safely. Guidance for staff on how to support the safe administration of medicines was not always in place or where it was, it was not sufficiently detailed to ensure they understood what they needed to do.

People were not protected from the risk of infection because staff did not always follow good practice in relation to wearing Personal Protective Equipment (PPE) or the handling of clinical waste. There was a malodour on the ground floor of the building.

Systems in place to monitor the quality of the service were not used effectively to identify shortfalls in quality. Reportable incidents had not always been identified affecting external bodies' ability to monitor the safety and quality of the service.

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

Rating at last inspection.
The last rating for this service was inadequate (published 10 November 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 the provider remained in breach of regulations.

Why we inspected
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.

We undertook this targeted inspection to check on specific concerns we had about medicines management, the management of the home and the identification and reporting of incidents in the service. This included events that we became aware of through third parties that we had not received formal notifications about as required by law.

Following the last inspection, we urgently imposed conditions on the providers registration in relation to

Chiltern View. One of these conditions was that the provider was to submit to us fortnightly updates on making the required improvements. We did not receive these updates after 24 October 2022.

We use targeted inspections to follow up on warning notices or to check concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

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

We have identified continued breaches in relation to medicines management, infection control and the management oversight of the home including how they identify and report incidents and accidents to protect people from potential harm.

Following this inspection we took enforcement action to cancel the registered manager's registration and to remove the location of Chiltern View from the provider's registration, which meant they could not continue to operate this service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question Inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Details are in our Safe findings below.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question Inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Details are in our Well-led findings below.

Chiltern View

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.

This was a targeted inspection to check on concerns we had about medicines management and management oversight.

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
This inspection was carried out by two inspectors

Service and service type
Chiltern View 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. Chiltern View is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. 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 was a registered manager in post, but they were not working in the service. The provider's operations director was acting as manager in their absence. Following the inspection,

the provider confirmed to us that the registered manager is no longer in post.

Notice of inspection
This inspection was unannounced. Inspection activity started on 12 December 2022 and ended on 10 January 2023. We visited the service on 12 December 2022.

What we did before the 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. We reviewed information we had received about the service since the last inspection. We considered feedback received from the local authority and professionals who work with the service. We wrote to the provider for an update about improvements to the service but did not receive a response. We used all this information to plan our inspection.

During the inspection
During the inspection we spoke with two people who used the service, and three staff including the acting manager and the deputy manager. We reviewed a range of records. This included care records for four people and medicine and supplementary records for multiple people, such as repositioning charts. We reviewed various records relating to the management of the service including records relating to the oversight of the service and how accidents and incidents were identified, monitored and reported.

Inspected but not rated

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 this key question was rated inadequate. We have not changed the rating as we have not looked at all of the safe key question at this inspection.

The purpose of this inspection was to check a concern we had about medicines management and to look at how the service protected people from the risk of infection. We will assess the whole key question at the next comprehensive inspection of the service.

At the last inspection, the service was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the management of medicines and the prevention and control of infection. At this inspection, not enough improvement had been made and the provider was still in breach of Regulation 12.

Using medicines safely

- Medicines were not managed safely. Following the last inspection where it was found that a person's insulin was not managed safely, responsibility for administering it was taken back by the district nursing team. However, no protocol was put in place to guide staff about their role in supporting safe administration. For example, what to do if the nurses were late and how long to wait before contacting them, monitoring the person to check for symptoms and whether the person should be offered food before they arrived. The medicine administration records indicated that the administration times of this time critical medicine had continued to be erratic. Although the relief manager had raised this as a concern with the nursing team and the local authority safeguarding team, no guidance for staff was in place for them to know what to do.
- People's care records in relation to medicines and medical conditions had not been effectively updated to reflect people's current needs. For example, one person's care plan in relation to the arrangements for administering their medicine had been updated to reflect a change, but also still referred to previous arrangements. This inconsistent information may be confusing for staff and could lead to inappropriate support being offered.
- Where people were prescribed medicines to be taken on a 'when required' (PRN) basis, protocols to guide staff on when to administer these were not always in place, or when they were, contained inaccurate or insufficient information. For example, a medicine prescribed for use in the event of bleeding was referred to as being prescribed for pain relief.
- Guidance to staff about medical treatment for one person in the event of an emergency was not sufficiently detailed to support staff to understand what they were required to do while waiting for paramedic support.
- One person had recently been prescribed anticipatory medicines. These are medicines that are prescribed for use as a person comes towards the end of their life to manage symptoms such as pain and agitation. Their end of life care plan had not been updated to give guidance to staff about what signs to look for and when to call the district nurse team to administer these medicines. This could have resulted in the signs

being missed and the person not receiving anticipatory medicines to aid them to have a comfortable and dignified end to their life.

Preventing and controlling infection

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. During the inspection we observed staff come out of one person's bedroom holding a bag of clinical waste and immediately entering another person's room still holding the bag. This put people at risk of infection. Although the cleanliness of the service had improved since the last inspection, there continued to be a malodour on the ground floor of the building.

● We were somewhat assured that the provider was using PPE effectively and safely. However, during the inspection we observed that two staff were not wearing PPE correctly to reduce the risk of infection.

The lack of effective and accurate guidance to staff to support the safe administration of medicines and the failure to follow good practice in relation to infection control were a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

● We were assured that the provider had safe systems for admitting people to the service although, at the time of the inspection admissions to the home were restricted.

● We were assured that the provider was responding effectively to risks and signs of infection.

● 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.

Inspected but not rated

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 this key question was rated inadequate. We have not changed the rating as we have not looked at all of the well-led key question at this inspection.

The purpose of this inspection was to check a concern we had about the management oversight of the service and how incidents and accidents were being monitored and reported. We will assess the whole key question at the next comprehensive inspection of the service.

At the last inspection the provider was in breach of Regulation 17(Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, not enough improvement had been made and the provider was still in breach of this regulation.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Since the last inspection the provider had put in place new systems to support the management oversight of the service including daily meetings and clinical review meetings. However, we found these systems were not yet used effectively to identify shortfalls in the quality of the service.
- Although we saw some evidence of improved management oversight of supplementary records since the last inspection, such as repositioning records and food and fluid intake charts, there were still occasions where people were not supported in line with their assessed needs. Where this was identified by senior staff, it was not always clear how this had been addressed. There also remained occasions where this was not picked up by senior or management staff. For example, the chart for one person requiring two hourly repositioning showed six occasions between 10 and 11 December 2022 where they were repositioned between 50 and 90 minutes late. This increased the risk of them developing pressure injuries.
- Quality monitoring systems were not used effectively to identify and address shortfalls in care documentation, including information relating to medical needs, end of life care and skin integrity care. This included a lack of detail, information that was inaccurate or inconsistent or out of date. At the last inspection we found that people's care plans contained information about the signs and symptoms of their medical condition but did not provide guidance to staff about what they should do if the person displayed those symptoms. Although the acting manager told us this person's care plan had been updated, this information had still not been added to the document. This meant the person may not have received appropriate care in the event of experiencing the symptoms of their condition.
- Quality monitoring systems had also not been used effectively to identify incidents, accidents or concerns and share information appropriately with other bodies as required.
- The management team had not identified when people still did not have access to call bells or another way to alert staff for assistance. Call bells were either not plugged in or not in place and sensor mats were positioned under people's beds which meant they would not be triggered if a person got, or fell, out of bed.

Systems in place to monitor the quality of the service and to identify reportable events were not used effectively. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

● Providers are required to display their most recent rating in a prominent place both on their website, if they have one, and within the service. Although the provider had displayed the rating from their last inspection on their website, they still had the rating from their previous inspection displayed in the service. Following the inspection, the provider confirmed they had addressed this, and the correct rating was displayed as required.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Section 33 HSCA Failure to comply with a condition The provider failed to comply with imposed conditions to seek written approval before admitting people to the service

The enforcement action we took:

Fixed Penalty Notice Served

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely and people were not adequately protected from the risk of infection

The enforcement action we took:

Notice of Decision to remove Chiltern View from the provider's registration and remove the manager's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not used effectively to monitor the quality of the service or to identify, manage and report incidents and accidents

The enforcement action we took:

Notice of Decision to remove Chiltern View from the provider's registration and remove the manager's registration