The Brandon Trust

Cheddar Grove 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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Cheddar Grove is care home providing personal and nursing care to seven people with a learning disability or autistic people. At the time of our inspection there were six people using the service.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

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

Staff were passionate about providing care that was tailored to the person. Relatives praised the home on the care and support provided to their loved ones. Regular contact was maintained with family and the person's named representative was involved in reviews of care. Overall, relatives felt communication was good. People continued to be well supported with meaningful activities in their home and the community.

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.

Infection control procedures and measures were in place to protect people from infection control risks associated with COVID-19.

People were supported by enough staff. The home was experiencing workforce pressures and agency staff were being utilised to ensure there were enough staff supporting people.

Staff understood how to protect people from poor care and abuse. Staff had training on how to recognise and report safeguarding concerns.

People had access to healthcare professionals when they became unwell or required specialist support. The interim manager was proactively working with professionals to improve communication and ensure people received care that was safe and meeting their individual needs.

Right Care:
People were not always kept safe as the advice of health professionals and risk assessments were not always followed.

Staff interaction with people was warm, caring and respectful. People were involved and staff were observed asking people how they wanted to be supported. Family members told us their relative were cared for and treated well.

Medicines were managed safely. Although during the summer they had experienced some difficulties with the pharmacist not supplying medication in a timely manner. Staff told us they were looking to change to a local pharmacist to aid improvement in this area.

Right Culture:
In the last two years there had been a high turnover of staff. There had also been a change of management. Health and social care professionals had raised concerns in respect of the communication between the team and themselves and as consequence not following their advice. An interim manager had been redeployed to assist with making improvements and providing leadership and direction to the team.

The staff were committed to getting it right for people. Care was person centred and tailored to each individual. Health and social care professionals were regular visitors to the service.

The provider and the manager had implemented a robust system to monitor the quality of the service. However, improvements were needed to ensure records relating to the care of people were consistently completed such as fluid charts, monthly summaries and epilepsy monitoring charts.

Rating at last inspection and update
The last rating for this service was good (published 16 February 2019).

Why we inspected
The inspection was prompted in part by a notification of an incident following which a person using the service died. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risks to people. This inspection examined those risks.

Since the death the management team had reviewed risks assessments and an interim manager had been brought into work with the staff team.

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 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 changed from good to requires improvement based on the findings of this inspection.

Enforcement and Recommendations
For enforcement decisions taken during the period that the 'COVID-19 – Enforcement principles and decision-making framework' applies, add the following paragraph: 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 found evidence that the provider needs to make improvements. We have identified breaches in relation to safe care and treatment and in good governance relating to record keeping. Please see the safe and the well led section of this report. You can see what action we have asked the provider to take at the end of this full report.

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

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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Cheddar Grove 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 completed by one inspector.

Service and service type
Cheddar Grove 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. Cheddar Grove 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
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. They were on a period of leave and an

interim manager had been redeployed by the Trust to support the home.

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. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the 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.

During the inspection
We spoke with two people who used the service about their experience of the care provided and spent time with others observing interactions with staff. We spoke with three members of staff, the interim manager, a representative from the Trust's quality assurance team, a representative from the Trust's human resources team and two health professionals visiting the service.

We spoke with three relatives and contacted a further three health and social care professionals about their experience of the service via email and telephone. We also had a virtual meeting with the nominated individual and the head of operations.

We reviewed a range of records. This included three people's care records, daily records and medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service including training data, staff rotas and quality assurance records.

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 good. At this inspection the rating has changed to 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

● People were not always kept safe. Health professionals had raised concerns that not all their advice had been followed. For example, one person had been given a sweet food that was conflicting with their eating and drinking care plan. There was a risk that the person could have choked. Whilst this had been reviewed and the food stopped the staff had not recognised the risks to the person.

● People had a record to capture what fluid they had received throughout the day. These had not been totalled and therefore people could potentially be at risk of dehydration.

● Not all staff had taken part in a fire drill. The interim manager was aware that this had not been completed in accordance with The Trust's policies and procedures. They were taking action to address this shortfall but there was a risk in the interim that staff would not know what to do in the event of a fire.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were systems to monitor and review risks to people, staff and visitors. Care plans included information on how to keep people safe. The interim manager told us they had arranged a meeting with the community learning disability team to review people's epilepsy profiles.

●The interim manager and the quality assurance team had recently reviewed all risk assessments and guidelines to ensure they were current and reflective of people's needs to ensure risks were minimised.

● Staff and people partnership to assess risks people might face. Where appropriate, staff encouraged and enabled people to take positive risks. For example, one person attended a local church every Sunday without staff support. This person told us they liked to go to church and their work placement.

● Checks were completed on equipment such as moving and handling equipment, fire equipment, electrical and gas appliances.

● People had personal emergency evacuation plans in place, which meant staff and emergency services knew what support people needed in the event of an emergency. There was a grab bag by the front door, which included information on how to evacuate safely, emergency blankets and a touch. A place of safety had been identified in the church, which was in close proximity to the home.

Systems and processes to safeguard people from the risk of abuse

● People were protected from the risk of abuse. Systems were in place to monitor any allegations of abuse to ensure these were reported appropriately and to monitor any subsequent actions.

● Staff had received training on safeguarding and understood their responsibility to report to the nurse and the interim manager. Staff knew how to report safeguarding concerns internally and externally.
● Relatives said the service was safe and their family member was provided with care that was safe. People looked comfortable with the staff supporting them.

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.
● The interim manager had reviewed all DoLS and had submitted one that was due in September 2022 and was chasing two outstanding authorisations that had been submitted in the earlier part of January 2022 where there had not been a response from the local authority.

Staffing and recruitment
● People were supported by sufficient staff. Staffing had recently been increased at night in response to a person's needs changing. This was being funded by the Trust in the interim, whilst they were awaiting funding from the placing authority. This showed staffing was kept under review.
● Although, there was sufficient staff, the home had experienced difficulties recruiting to vacant posts, which meant there was a high usage of agency. Staff said at times this had been difficult as unfamiliar agency staff did not always know people's support needs. In response the interim manager was liaising with the named agencies to rectify this with block booking specific agency staff.
● Relatives told us there had been lots of changes of staff in the last two years.
● Every person's record contained a clear one-page profile with essential information and dos and don'ts to ensure new or temporary staff could see quickly how best to support them. This included information about how to safely support each person with eating and drinking.
● Safe recruitment systems were in place. The service was experiencing work force pressures and had recently changed their recruitment processes in accordance with the interim guidance from DHSC.

Using medicines safely
● People's medicines were managed safely. People's medicines were stored in a locked cupboard in their bedrooms. This lent itself to a person-centred approach to people's medicines.
● Medicines were ordered, stored, administered and disposed of safely.
● Medication audits were completed monthly along with regular stock checks to ensure people received their medicines when needed. Only staff that had been assessed as competent were able to administer medicines to people. This was checked annually or when errors had occurred.
● The interim manager and the staff were aware of the guidance about reducing medicines using the principles of STOMP. STOMP stands for stopping over medication of people with a learning disability or autistic people pledge with psychotropic medicines.
● Some of the people living in Cheddar Grove were unable to tell staff they were in pain. Pain management

assessments were in place.

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 supporting people living at the service to minimise the spread of infection.

● 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. However, two staff told us they wore their face masks for longer periods than government guidance. This was shared with the manager who said they would remind staff when they should change their mask and the duration it should be worn.

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

● 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 demonstrated they had followed the government guidance on visiting arrangements. Friends and family were able to visit the home with no restrictions. This allowed people to stay in contact with their relatives during the COVID-19 pandemic. A person told us their relative had recently visited them and they had gone out for lunch. Another person had been on a family holiday with a member of staff supporting them.

Learning lessons when things go wrong

● An analysis of accidents and incidents was undertaken to identify any themes and trends, specific to an individual or general to the home. These were reviewed by the senior management team and their health and safety team.

● Where incidents had occurred, these were investigated, and lessons learnt. Learning was shared across the whole of the Trust to aid improvement and to mitigate further risks.

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 good. At this inspection the rating has changed to 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

- During the inspection we found improvements were needed to some of the records, such as people's monthly summaries not being completed for August and September 2022. This meant there was no monitoring in place for how people had been supported over a four-week period with their health, activities and general wellbeing. Fluid charts had not been totalled up at the end of the day for people meaning if a person had not had sufficient fluid this could not be rectified. We also found that a person's epilepsy overview had not been completed on two occasions when the person had a seizure. Whilst no one had come to harm improvements were needed.
- Visiting health care professionals had raised concerns about the leadership within the home, lack of management direction, high use of agency and as a consequence the safety of people living in Cheddar Grove. Staff said at times they had not felt supported. The interim manager was aware of the concerns and was addressing these with an action plan in place.

There were gaps in records and the governance arrangements, which potentially put people at risk of receiving unsafe care. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Handover records included a section to record fridge temps and cleaning this had not been completed as this was duplicated on another record. We recommend the provider reviews records to avoid duplication.
- A representative of the provider visited monthly to review the service and support the registered manager. The registered manager compiled monthly reports to enable the provider to monitor the service in respect of service delivery, staffing and concerns.
- The Trust's quality team were supporting the interim manager in identifying areas for improvement. Audits and action plans were in place to drive improvement.

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

- Relatives spoke positively about the care and support that was in place with no concerns being raised. A relative said, "X (interim manager) had contacted them in respect of the management changes in the home and introduced herself". Another relative said, "Really good service". Both relatives said over the last two years there had been a high turnover of staff, but they felt this had not negatively impacted on the care of their loved one.

● Another relative said, "We are immensely grateful to the staff" and told us about how their loved one's quality of life had blossomed since living at Cheddar Grove.
● The provider had a clear vision for the direction of the service that demonstrated ambition and a desire for people to achieve the best outcomes possible. This was echoed by the interim manager and the staff we spoke with. A member of staff said, "It is all about putting the person first".
● The previous manager was responsible for other services and had split their time between these and Cheddar Grove. The interim manager said they were working solely at Cheddar Grove to support the team and drive improvements. They were passionate about delivering safe care that was person centred.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff meetings had not been regular. The interim manager was in the process of organising team meetings and house meetings. The last team meeting had been held in February 2022 and a house meeting for people living in the home in May 2022. A team leader meeting had been held the day before the inspection.
● The interim manager had arranged a number of meetings with the community learning disability team over the forth coming week including an epilepsy nurse to ensure individual protocols were reviewed and remained current.
● Relatives confirmed they were invited to meetings in relation to health and reviews of care and there was good communication with them about any changes to their loved one's wellbeing.
● People were able to maintain contact with family and friends. There was an open visiting arrangement. People had been supported to go on holiday with three people returning from Blackpool the week prior to the inspection. A member of staff said they had also supported one person to have a holiday with family.
● People were supported to take part in activities of their choosing. One person who had a love of animals was supported to keep Guinea pigs, their relative said this was really important to them. They told us about Zoo trips that the staff had organised. People had also experienced an activity where exotic animals had visited the home. It was evident people were seen as individuals taking into their consideration their equality characteristics.
● Staff knew how each person expressed if they were distressed or unhappy about something. They closely monitored changes in people's behaviour. This was important as most of the people were unable to verbally communicate if they were unhappy.

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 provider understood their responsibility to report significant events to the Care Quality Commission and Local Authority safeguarding team to protect people.
● The provider understood the Duty of Candour which aims to ensure they are open, honest and transparent with people, their relatives and others in relation to care and support. The provider, registered manager and interim manager had been open, transparent in relation to a recent death working with the person's family, the local safeguarding team and the Care Quality Commission.

Continuous learning and improving care
● Concerns in August 2022 had been raised by visiting health professionals that there were delays in staff receiving training on dysphasia and specialist training on an epilepsy rescue medication. The delay in staff receiving this training could potentially put people at risk of harm. Assurances were provided by the interim manager who told us this was being delivered in the forthcoming month with two dates arranged to capture all staff and agency staff that worked regularly in the home.
● The provider ensured staff had received training in supporting people with a learning disability and/or autism. This formed part of the induction for new staff. Staff confirmed they completed an induction when

they first started and were well supported.

● The interim manager had reviewed all training and an action plan was in place to address any gaps in mandatory training including that identified by visiting health care professionals. A member of staff said, "I have done most of my required training, except Mental Capacity which I am booked in for". Staff were aware of the training requirements that were expected of them.

Working in partnership with others

● Guidance from health care professionals advising staff how to support people with their needs safely was not always followed. These concerns were shared with us, the service and the local authority. The interim manager was aware of the concerns and was working with professionals and the staff team to address these and ensure people were safe.

● People were encouraged and supported to be involved in the local community. One person told us how they regularly went to church, another person told us they liked to go to the local shops and regularly went for walks.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not done all that is reasonably practicable to assess and mitigate risks. This included ensuring all staff participated in a fire drill. Staff had not always followed the advice of health professionals to ensue people were kept safe in line with the individual's care plan.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement a robust governance system to ensure records relating to people's care were completed including monthly summaries of care for people, that food and fluid charts were totalled and epilepsy monitoring records were consistently completed. This left people at risk of receiving unsafe care.