Musgrave Ventures Limited

Chalcraft Hall Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Chalcraft Hall Care Home is a residential care home providing personal care to 16 people aged 65 and over at the time of the inspection. The service can support up to 20 people.

Chalcraft Hall Care Home accommodates people in one building, there are two wings to the service and the home is on two floors. All people at the home share a dining room and lounge. The home provides specialist care for people with dementia.

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

People were offered few activities, and no separate spaces to take part in their interests. There were not always enough staff to support people to remain active, for example to take a walk in the garden. People were restricted from leaving the home to keep them safe, these decisions were not always documented. There was a lack of evidence that people's choices were respected.

The manager had recently left the service and the provider was acting as manager at the time of the inspection. Neither senior staff nor the provider had identified past issues with documentation or understood the impact this could have on people. The lack of clear oversight and correct documentation left people at the risk of harm. The provider was preparing an action plan to address this. The provider was taking time to speak to all staff and reviewing working patterns to create a more cohesive team. Staff said they had been nervous when the manager left but the provider had implemented positive changes. Policies, procedures and audits at the service needed review.

While we did not see any evidence of harm to people at the home, care plans were not always kept up to date. This meant staff were acting on old instructions and may not have been taking recent changes in a person's choice of care into account. While some staff knew people well, new or agency staff would not be acting on people's current care needs. People at the home were happy. We saw friendly interaction with staff. People told us they liked the staff at the home. Staff understood the importance of safeguarding and the provider worked closely with the local authority. Issues regarding safety and risk continued to be overseen by the local safeguarding team.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible or in their best interests; the policies and systems in the service did not support best practice.

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 Good (published 22 February 2019).

Why we inspected
We received concerns in relation to people's care needs, staffing, and management of the service. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions before the inspection. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe, effective and well led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Chalcraft Hall Care 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 will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to people's freedom and consent to care and of good oversight of the service 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.

Details are in our well-led findings below.

Chalcraft Hall Care 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 Care Act 2014.

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 team consisted of two inspectors.

Service and service type
Chalcraft Hall Care Home is a 'care home'. People in care homes receive accommodation and 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.

Notice of inspection
We gave the service 18 hours' notice of the inspection. This was because of the COVID-19 pandemic and to help plan the visit to ensure the visit was safe.

What we did before the inspection
We reviewed information we had received about the service since the last inspection and we spoke to the local safeguarding team. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We used all of this information to plan our inspection.

During the inspection-
We spoke to three people who use the service, three members of the care staff, the chef and the provider. 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 three people's care records and multiple 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 policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, staff records, audits and staff rotas.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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's risks were assessed and recorded in their care plans. Some care plans contained conflicting information. In one care plan for example, staff would not know what a person could eat safely, because guidance on separate pages varied. We spoke to staff on duty at the time of the inspection and found they knew the person well and would be confident in caring for them and knew what they could eat. We did not have assurance that all staff knew people well, this was especially important as the home had a high staff turnover and might need to use agency staff during the COVID-19 pandemic. We spoke to the provider about the lack of consistency in people's care plans, and the provider told us they were reviewing them.

● While people were protected from risk of harm, this was not always person centred. Care plans lacked mental capacity assessments (MCA) and staff made assumptions about people's ability to make choices. For example, a person living with dementia was cared for in bed, there was no best interest decision recorded for this choice.

● People were not encouraged to take positive risks, for example people were not able to use the garden without staff assistance due to key coded door locks. On the day of the inspection it was warm and sunny and we did not see staff ask people if they would like to go outside.

● Staff told us that people were not able to go out safely alone. People were prevented from leaving the building by coded door locks both on the garden gate and exterior doors to the home. Not everyone at the home had a Deprivation of Liberty Safeguarding (DoLS) authorisation in place. We spoke to the provider about the importance of assessing people for risk and mental capacity and where people were restricted from leaving they must have DoLS authorisation in place. The provider said they would seek guidance on MCA and DoLS authorisations.

Staffing and recruitment

● Before the inspection we asked the provider for copies of staff rotas and the dependency checker he used to decide on safe staffing levels. There had been some staffing issues due to the COVID-19 pandemic. On the day of the inspection the provider told us the staffing level was safe based on the dependency checker.

● We saw there were enough staff at the home to keep people safe and to provide essential care such as supporting people to drink or going to the toilet. The number of staff on duty meant there were not always staff available to interact with people outside of essential physical care, people's emotional needs were not supported. A person cared for in bed was left alone for most of the day because there were no available staff members to sit with them. A staff member told us "I feel sorry for [person] as this isn't a nursing home, and she needs people with her all the time." Staff did not encourage people to voice their choices in daily

activities, for example they did not ask people before turning the television on or off.
● Staff did not always have supervision or support when they started working. There was no evidence to show regular staff supervisions or appraisals. Due to a high turnover of staff some staff had been promoted to senior roles without gaining extra qualifications and there was no manager to support them. Where staff trained new staff without having any training qualifications themselves, there was a risk of new staff learning incorrect techniques, for example with infection control or moving and handling, this put people at risk of harm.
● The senior staff member overseeing medicines at the home had limited understanding of safe medicines administration.
● Staff spoke to people in a polite and friendly way and we saw people and staff interact well with each other. The provider knew people by name and people were happy to talk to him. A person told us, "I like the staff they talk to you and don't ignore you."
● Staff were recruited safely and had relevant background checks before they started working with people.

Using medicines safely
● While medicines were administered and recorded safely, where people received medicines covertly, for example hidden in food, mental capacity assessments had not been carried out nor best interest decisions made and recorded correctly.
● Medicines that are be hidden in food or drink need to be done so safely and effectively and staff had not sought guidance about the safest way to administer the medicines. Staff contacted the pharmacy during the inspection to correct this.
● Medicines administered were recorded on charts, with reasons if a medicine was not given, or could not be given. A senior staff member carried out regular audits of the medicines, including checking stock levels and expiry dates.

Learning lessons when things go wrong
● Lessons were not always learned when things went wrong, the provider was working to improve that. Themes of incidents or accidents were hard to recognise due to the way they were recorded at the service. The provider told us, "I'm identifying how to improve things. I'm looking at a systematic way to spot themes in incidents and accidents."
● Where themes from accidents were noticed, care changed as a result. An example is a person who frequently fell at night, staff realised the person did not like to stand on a pressure mat which was in place for their safety, to alert staff if the person got out of bed, this was causing them to stand at the edge of the mat and fall. The mat was removed and replaced with light beam technology that still alerted staff to help, without distressing the person.

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risk of abuse or neglect. Staff knew people well and could recognise if people were not happy.
● Staff understood the importance of safeguarding and reporting concerns. They were aware of ways to contact the local safeguarding team or the CQC when they had concerns. A staff member said "I would report concerns to [provider] . Safeguarding might be bruises, witnessing lack of care, not feeding people, a resident with a change in behaviour towards staff or other people, flinching or being scared." The provider worked with the local safeguarding teams to improve safety at the home.

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 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 promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks could be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 Act 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 MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- The provider was not working within the principles of the MCA. While people had DoLS authorisations in place, mental capacity assessments and best interest decisions were not recorded and could not be located when asked for. This included where a DoLS authorisation specified the assessments should be added within a set time limit and this had not been completed.
- People were deprived of their liberty by the use of coded door locks on both the home exterior doors and the garden gates, not everyone had a DoLS authorisation in place. This meant people were deprived of their liberty illegally and were unable to leave the home, even to use the garden, if they wished to. We spoke to the provider about this during the inspection and they confirmed that they intend to review everyone's MCA and DoLS authorisation requirements.
- Staff were not clear in understanding the MCA. Staff could not use care plans to know about best interest decisions as these had not been carried out or recorded, so staff made decisions for people when necessary during the day.

People were being deprived of their liberty without legal authorisation, and without correct Mental Capacity

Assessments. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People lacked stimulating activities at the home and people sat in the lounge for periods of time with only a television or radio for entertainment. Staff were task focused, and did not often have time to stop and have conversations with people. The activities coordinator role was vacant at the time of the inspection. After the inspection the provider told us this role was now filled and activities would be planned for people.

● We saw people sitting quietly in rows in the communal lounge. We did not see staff ask people what they wanted to watch on the television. One person told us she preferred to spend time in her own room as she had her own television there, she said "No one does anything in here."

● Staff supported people with activities when they did have time and we saw a member of staff help a person with a visual quiz. Activities were limited as everything took place in the main lounge. There was little opportunity for people to choose an activity and the only other area for people was the dining room which was also used for meals and family visits.

● People at the home were happy and we saw friendly interactions between people and staff.

● After the inspection the provider told us that before COVID-19 restrictions there had been visits by external entertainers and the provider told us they were considering how to accommodate entertainers again safely in the future.

Staff support: induction, training, skills and experience

● Staff understood the day to day care of people at the home. The training matrix was not up to date and it was not clear what training had been completed or was due. If staff training records are not current there is a risk staff are working untrained, or their training has lapsed and they may not be aware of current guidelines. We spoke to the provider about this during the inspection. The provider said that they would update and refresh the staff training package, and they sent evidence of this change after the inspection.

● Staff had been supported by the provider since the registered manager had left. This support was limited as the provider had no formal care training. Staff had qualifications for their role or were working towards them. Senior care staff had not always completed their qualification before taking on the senior role.

● Staff had induction training when they began working at the home, and the provider was in the process of changing the training supplier due to restrictions on obtaining face to face training during the pandemic.

Supporting people to eat and drink enough to maintain a balanced diet

● A person at the home was on a pureed diet. Staff were aware of the help they needed and the chef told us they knew how to prepare their food. The chef prepared food for people's preferences, such as a vegetarian based diet or calorie enriched diets when required.

● Most people were able to manage their own meals. Staff asked people what they wanted to eat and we saw people were offered several alternatives if they did not like the main choices.

● People were offered tea and biscuits throughout the day and fruit and cold drinks were available in the lounge whenever people wanted them.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● While GPs made routine phone calls to the home weekly, staff were not proactive in their approach when working with other agencies to provide good care. Routine visits by specialist health professionals for people with ongoing conditions were not organised to ensure people remained in good health.

● Where people had issues with swallowing safely we did not see evidence to show regular visits by the speech and language therapy (SALT) team. The SALT team assess people who may be at risk of choking or

need soft food or thickened drinks. A person who was eating pureed food had no record of a SALT team assessment in their care plan. The decision to feed them pureed food had been made with no evidence of risk assessment, and the last visit by the SALT team was over three years previously. We spoke to the provider about this during the inspection and they planned a meeting to review the person's care.

● When asked about physiotherapist visits a staff member told us she could not remember one in the past year, she said, "Most people are independent with frames and sticks, there hasn't been much deterioration over the year for residents."

Adapting service, design, decoration to meet people's needs

● The home was clean and uncluttered and had a lift for people to use to get to their rooms upstairs. There was a large, well-lit lounge and dining room for people to use. The lounge was well used during the day, our observation showed that the layout of the lounge of chairs in rows did not stimulate interaction between people.

● Visiting by friends and relatives was restricted due to the COVID-19 pandemic. Visits were booked in advance. Visitors were able to meet with people using a 'pod' (temporary exterior room) which allowed distanced visiting during the pandemic. The 'pod' was being used against the dining room window, the provider was identifying alternative locations with improved privacy.

● Posters around the home showed past activities, and residents and staff enjoying events together.

● People had choice of how to wash or be washed and were able to access either a bathroom or shower if their room did not have en-suite facilities.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Working in partnership with others

- The registered manager had left the service in the month before the inspection and there was no current registered manager at the service, the provider was fulfilling this role.
- Audit procedures required review. The provider was reviewing the auditing processes at the home. People were prevented from leaving the home, and paperwork did not always support this restriction. Medicines were not reviewed by a pharmacist to ensure they were being administered safely. Neither the previous manager nor the provider had identified issues with the lack of DoLS authorisations, the missing information in care plans relating to MCA, or the lack of communication with the pharmacy about covert medicine administration.
- People's needs were not always reviewed by all appropriate healthcare specialists. Dated visits by SALT teams in the care plans of people who had issues with swallowing were over three years old, which meant changes in people's needs were not identified. Neither the previous manager nor the provider had identified this as a risk.
- Staff were clear about their roles and how to escalate issues within the team. Staff had meetings with the provider to improve relationships within the team since the manager had left. Staff told us, "'Initially it felt stressful [when the manager left] but it's settled down now. [The provider] is approachable for concerns."

While we found no evidence that people had been harmed, systems were either not in place or robust enough to demonstrate audits were carried out effectively, or that input from other health professionals was sought appropriately. This placed people at potential risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The provider was keen to foster a positive culture with the staff and strengthen the team. Staff told us he had changed the way they worked and they felt it was for the better. We had received mixed feedback from staff before the inspection. At the inspection a member of staff told us the new ways of working were "more flexible and positive." Another member of staff said, "It's a strong team, we communicate well, staff meeting is every month, we have morning and evening handovers. There is a senior's book for everyone to access with information about changes and updates."

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 the duty of candour and was keen to keep family and friends informed about changes at the home.

● Relatives were kept up to date with any changes at the home. After the manager left, a letter was sent to all relatives to let them know how the change in management would affect people and staff at the home.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

● Due to the COVID-19 pandemic there was limited scope for people to remain connected to local groups and services. Before the pandemic people had access to attend local churches.

● People were able to keep in touch with relatives and others from outside of the home either using technology, such as video calls on tablet computers or using the 'pod' for visits in person.

● The provider was actively looking at way to improve the service that people received at the home. A staff member told us, "I can only see things getting better now [the provider] is here. Since he arrived he really wants to improve everything and has gone round [the building] to identify what needs to be updated. He's bought a new washing machine and tumble dryer, computers and beds."

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 11 HSCA RA Regulations 2014 Need for consent People did not have Mental capacity assessments recorded in their care plans and some people did not have Deprivation of Liberty Safeguards authorisation although they were not free to leave the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Audits were ineffective at identifying risks to people, including missing paperwork. Medicines audits had failed to identify risks with the way medicines were being administered. Staff training matrices were not up to date.