Irvine Care Limited

Chiltern Court Care Home

Inspection report

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Ratings

Overall rating for this service	**Good**
Is the service safe?	**Good**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

The inspection took place on the 12 and 13 October 2015. It was unannounced.

Chiltern Court provides residential and nursing care for up to 53 older people; at the time of the inspection 29 people were living in the home. The home manager had been in post for six weeks, and intends to register with the Care Quality Commission (CQC) in the near future. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe living in the home. They told us their needs were met, and when they needed help from staff their requests were responded to quickly. Where people were not able to summon help, staff made regular checks to ensure their wellbeing.

Summary of findings

People's needs were assessed and care plans reflected how staff would meet their needs. Risk assessments were in place to ensure the risk of injury to staff and to people was minimised.

Records were frequently updated in relation to the care provided, and information about people was shared in the handover meetings and the flash meetings which took place each day.

The systems used for recruiting staff included making checks on candidate's backgrounds. This was to ensure they were safe to work with people.

Medicines were stored safely and securely. We saw that people's medicines were given safely by the nurse who recorded administration on the medication administration (MAR) sheet. Training had been given to the nurses by a visiting pharmacist to ensure medicines were correctly and safely stored, handled, administered and disposed of.

People had mixed views as to whether there were sufficient numbers of staff to care for them. We found that although staff were busy, they were able to meet people's needs. The provider had an assessment tool in place to gauge the staffing levels required to meet the needs of people at any one time.

We found records related to staff training and supervision showed staff were not receiving the support and guidance in line with the provider's policy. This meant the provider could not demonstrate staff were adequately trained and supported to carry out their role.

Staff knew about the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). This meant where people were unable to make decisions for themselves, staff acted in a way that was agreed was in the person's best interest.

People's health was maintained and where professional advice was required to assist people to remain healthy this was sought by staff. For example, dietician and GP.

People told us and we observed staff caring for people in a sensitive and appropriate way. They demonstrated a kind and caring nature and they were knowledgeable about people's needs and how to meet them. Care plans recorded people's choices and preferences and these were respected by staff.

There was a range of activities in the home to minimise the risk of social isolation. The manager was aware of the risk for people who remained in their rooms all day that they may become lonely. They intend to widen the range and availability of activities by engaging with the local college to provide students to support people with their interests.

People told us the service was well managed and they had noticed improvements since the new manager came into post. Staff commented on how supportive and approachable the management were. Quality assurance checks had been completed and were on going alongside feedback from people which was used to improve the quality of the service to people.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People were able to summon help through the use of call bells and staff responded quickly. Where people weren't able to use call bells staff made regular checks on them.

Checks were carried out on staff prior to employment to ensure as far as possible they were safe to work with people.

Records showed systems were in place to administer, store and dispose of medicines safely.

Good

Is the service effective?
Some aspects of the service were effective.

Records related to the training and supervision indicated that not all staff had received the support necessary for their role.

Staff had a basic understanding of the Mental Capacity Act 2005 and how this applied to their role. This ensured people's rights were protected.

People's health including their nutritional needs were monitored and supported by staff and where necessary external professionals. For example GP.

Requires improvement

Is the service caring?
The service was caring.

People were treated with respect and dignity by the staff. They told us they were well looked after and the staff were "kind".

Staff knew about people's preferences and choices.

Good

Is the service responsive?
The service was responsive.

Activities were available for people to participate in, and there were plans in place to increase these and make them more accessible and offer a wider choice.

Complaints and feedback were listened to by the provider and responded to in a timely and appropriate way.

Good

Is the service well-led?
The service was well led.

Staff, people and visitors told us the new manager listened to their comments and acted upon them.

Good

Summary of findings

Quality assurance audits were regularly undertaken and the findings acted upon to improve the quality of the service to people.	

Chiltern Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 12 and 13 October 2015 and was unannounced.

The inspection team consisted of two inspectors and an expert by experience that had personal experience of caring for someone who uses this type of care service.

Prior to the inspection the provider completed and returned to us provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed previous inspection reports and other information we held about the service including notifications. Notifications are changes or events that occur at the service which the provider has a legal duty to inform us about.

We spoke with 12 people who lived in the home, four visitors and 11 staff including the manager and the peripatetic manager and the regional manager. We reviewed six care plans and medicines records and records related to the running of the service.

Good

Is the service safe?

Our findings

People told us they felt safe using the service. One person told us "Of course I feel safe. They always support me to make sure I can manage." A visitor told us "The residents are very safe here I have never noticed anything of concern when I am around, I am confident."

We observed that people had call bells in their rooms to enable them to call staff for assistance. Some people were able to operate these. Staff told us that people who were not able to use their call bells were checked regularly and records verified this. We observed staff responded quickly when call bells were activated. When a person we were speaking with pressed their call bell, a carer arrived promptly. People who were not able to operate call bells were checked at least hourly.

We were told prior to people being admitted to the home their needs were assessed. Documents showed risks to people's health and welfare had been assessed and risk assessments had been completed. Care plans informed staff how to reduce the risk of injury to themselves and to people. For example, the risk of malnutrition, moving and handling, infection control and skin integrity. These were reviewed frequently and kept up to date. Staff told us care plans reflected people's changing needs and included information on any special requirements people needed. They told us they were kept informed of any changes to people's immediate care needs during the shift handover and at the 'flash' meetings which were held at 11am each day.

Senior staff carried out regular daily and weekly checks to monitor the quality and safety of the care provided. On a daily basis they observed staff caring for people, spoke to people about their satisfaction with the care and checked the medicines records and the environment. This was to make sure people were safe and happy with the care being provided. Where issues were identified, corrective action was taken through training, support or disciplinary procedures.

The provider knew how to recruit staff and how to carry out the necessary checks to make sure they were suitable to work with people. These checks included evidence of disclosure and barring service (DBS) checks. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. Records showed applicants had completed application forms and references had been obtained from previous employers. Pre-employment health questionnaires and follow ups were carried out to ensure staff were fit enough to work with people.

We reviewed the ordering, storage, administration and disposal of medicines with the nurses at the home. We saw that the service had a medicines policy which covered topics such as what to do in the event of a medication error and who to inform. We were told that a pharmacist had recently been supporting the home in establishing good medicines practice.

We noted the clinical room was crowded with four medicines trolleys, two wall cabinets and two refrigerators. This made manoeuvring and accessing the medicines difficult. We were told after some air conditioning work had been completed two of the trolleys would be relocated to the first floor. This would improve the situation for staff in terms of accessibility. The trolleys were locked to the wall to ensure their safety and security.

Twice daily temperature checks were carried out for both room and fridge temperatures. We saw that these were within the correct range.

When we observed a medicine round on the ground floor, we saw that people's medicines were given safely by the nurse who recorded administration on the medication administration (MAR) sheet. We did notice that whilst some staff explained to people what medicines they were being given and why, this did not always happen.

Protocols for the administration of 'as required' medicines were available. These protocols provided guidance as to when it was appropriate to administer an 'as required' medicine and ensure that people received their medicines in a consistent manner. We were assured that all people within the home were having their 'as required' medicines offered to them when they needed them. One person told us "I get my medication and can ask for pain relief and get it all the time."

The provider's medicines policy included a section on the administration of controlled drugs. We saw that controlled drugs were stored according to the safe custody requirements under the Misuse of Drugs legislation. Records showed the controlled drugs had been

Good

Is the service safe?

administered correctly. We checked the actual number of medicines in the cupboard against the records, these tallied. When each medicine had been administered these had been signed and witnessed by two nurses.

Medication audits were undertaken, and current medication procedures were reviewed by the visiting pharmacist. They made recommendations on how systems and practice could be improved.

People's views about whether there were sufficient numbers of staff available to support them were varied. On the day of the inspection there were two nurses on duty with five staff. These staff worked over two floors. Two people we spoke with who lived on the ground floor told us that they thought there should be more care staff. One person said: "Staff are very nice. The only trouble is we haven't got enough of them. There's only two on today, usually three but it used to be four." Another person said "It's a pity there's not more." We discussed this with the manager and peripatetic manager. They explained that currently the home was just under half full. This meant staffing levels had been reduced in line with the number and needs of people. They had a dependency assessment tool to calculate the number of staff required. The manager told us they had factored into the equation the lay out of the building. Checks had been carried out on the workload of staff through observations by managers. Rotas showed the identified number of staff required were present. An ongoing challenge for the service was the recruitment of nurses for night shifts. We were told three vacancies were presently held by the home. Agency staff were used to cover the vacancies, and to provide continuity of care the same agency staff were used.

Safety checks were undertaken to ensure the safety of the building and the equipment, this included maintenance of the water supply and storage tanks to prevent legionella and the fire equipment and alarm systems. Documents demonstrated regular fire drills were carried out at the premises.

Requires improvement

Is the service effective?

Our findings

People using the service said that their needs were met by staff; they said they had the knowledge, skills, experience, and the right attitudes. One person told us "I think they manage to give everyone the best individual care." Another person said "They seem to know what they're doing. I think they do get training."

All new staff were expected to complete an induction, which included training in areas such as safeguarding, fire safety, first aid, moving and handling, basic food hygiene, and infection control. However, the records related to training showed some gaps. For example, one member of staff had not completed any training since they started working in the home in May 2015. Another staff member had completed three out of the 12 training courses deemed as mandatory by the provider since commencing employment in June 2015. A report was given to us which showed 74% of staff had completed the mandatory training, however three staff had not completed any training according to the records we were given.

Staff told us they undertook a period of 'shadowing' an experienced staff member before providing care independently. As the new staff member became competent their competencies were signed off by a mentor during the induction period. Documents verified this. The manager told us they tried to arrange the staff rosters to allow the mentor and the new staff member to work on the same shifts. By working together the mentor would be able to assess the quality and competency of the care provided. Any issues would be addressed directly with the new staff member or through supervision and appraisal.

The provider's policy on how often staff should receive supervision from their supervisor stated six times a year. We looked at the supervision records, whilst some staff had received regular supervision, not all had received supervision in line with the provider's policy. One staff member who had not completed any training since they commenced employment in May 2015 had also not received any supervision according to the records.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us they were aware of this deficit. They showed us a new supervision matrix they were putting together, this would enable them to see at a glance who required supervision and when. This would enable them to plan and keep up to date records of when supervision had taken place. The manager told us since they had started working in the home they had worked with staff in providing care to people. As a result they had been able to offer advice and guidance to staff on how to improve in their role. Documents verified this. As a result improvements had been noted. We received positive feedback from one person about a staff member who had been supported by the manager to improve on their practice. The person told us the staff member "Is one of the best carers".

The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) set out what must be done to make sure the human rights of people who lack the mental capacity to make decisions are protected. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

Records showed people's mental capacity had been assessed. Some people who lacked the mental capacity to make decisions for themselves had given their representatives the power of attorney. A power of attorney is where someone trusted by the person is granted the legal authority to make decisions on their behalf. Where representatives had power of attorney records confirmed this. This ensured the home knew who to consult when important decisions needed to be made. Other records showed where people lacked the capacity to make their own decisions; the home had acted in their best interest.

Records related to the number of staff trained in understanding the MCA and the DoLS were unclear. However, staff we spoke with had a basic understanding of the Act and how it related to the work they undertook with people. A nurse we spoke with showed a good understanding of the MCA principles. The nurse was able to discuss the applications the home had made for authorisations to legally deprive people of their liberty through the use of bedrails. This was to ensure people's safety. Care staff told us the purpose of the MCA was "to empower people." They showed an understanding of acting in people's best interests.

Where people had been assessed as requiring support with eating and drinking this formed part of the planned care they received. We saw people had a jug of fluid in their

Is the service effective?

room. A person told us "They always fill that up at night time." We also observed a variety of drinks being offered to people regularly, for example mid-morning and mid-afternoon.

People told us they were happy with the food provided. A person told us the home's chef was "Very good, if you ask for something he'll do it". The person explained that, because neither choice of main meal on a day later in the week was appealing, the chef was preparing a cheese and onion omelette for them. They told us they were weighed every month. They said that they managed well with food; however previously, "I was losing weight. They put me on milkshakes." People were offered fortified diets (e.g. with added cream or cheese) and in some cases prescribed food supplements to ensure their nutritional intake was adequate.

Where people were at risk of choking their needs had been assessed by speech and language therapists (SALT). We saw their recommendation of thickening drinks had been followed through by staff. Staff knew people's individual dietary requirements and directions for thickening drinks were in people's rooms. We met with the chef, they knew about people's dietary needs and preferences. They regularly met with people to discuss how happy they were with the meals. We observed a good rapport between the chef and the people living in the home.

We observed lunch time and saw good interactions between people and care staff. Care staff checked with the people if 'they were Okay' .People ate well and appeared to enjoy their meals. One person who appeared reluctant to eat their meal was supported by a staff member who encouraged them without taking away their independence. They repeatedly returned to the person and spoke quietly and gently to them until they started to eat their meal.

A range of professionals were involved in assessing, planning, implementing and evaluating people's care and treatment. During our inspection we attended the weekly meeting between a nurse and the GP. A consultant geriatrician was present during a review of people's health needs. Medication was reviewed and diagnostic tests requested. The doctors then carried out a 'round' to see people whose health was causing concern.

At this meeting, the nurse and medical staff considered 'do not attempt cardiopulmonary resuscitation' (DNR) orders and advance care plans for people for whom this was appropriate. The importance of a face to face discussion with the family, particularly when a person lacked capacity, was discussed. Documents showed SALT referrals had been made for people requiring support with eating and drinking and tissue viability referrals had been made to advise on the care of people's skin.

Good

Is the service caring?

Our findings

People told us the staff were caring. One person said "The staff here are all very good," They treat you with respect and dignity." Another person told us "I think they're very kind, they never shout."

People described their care to us as excellent or very good.

We observed the home had a calm and relaxed atmosphere. Staff knew people and their care needs well. They were caring and considerate in their approach to people and spoke to them in a friendly but respectful way. People spoke positively about the home and the staff particularly. A person told us "I'm quite happy" others told us they were "well looked after" and "They're very kind to me."

Staff knew about the people's preferences. People told us they were given choices by staff and the staff respected their views and opinions on how they wished their care to be provided. One person told us how their preferred drink was water. We noticed there was a jug of water on their table, they told us the staff were good at keeping it filled. We read their care plan it had correctly recorded their preferred drink was water. Another person enjoyed gardening. Due to health reasons this posed a risk to the person if they did not have the right equipment. The manager told us the person did not always want to use the equipment provided to keep them safe. After discussions with the person and explanations given we saw the person going out to garden with the correct equipment in place. This meant they could continue to be independent in pursuing their hobby.

We were told of one person who was resistive to care. The person had the mental capacity to make decisions for themselves about how their care was provided. However, the way they wished their care to be provided sometimes placed the staff and themselves at risk. Through discussions and explanations an agreement was reached with the person about how staff could carry out their care in a safe way that was acceptable to them. These conversations with the person were on going and sometimes on a daily basis.

Care plan records demonstrated the choices people were offered and how staff encouraged people to remain independent. For example, one record reported how a person did not wish to get out of bed before 9.30 am. We spoke with the person who did not get out of bed until 11 am on the day of the inspection. They told us this was their choice and this was respected by staff. Documents showed where able, people had given consent to the care they received. Records demonstrated people had been given choices and these had been respected. For example, people had been given the option of having the flu vaccination. We read one person had refused.

People and relatives told us they had been involved in reviewing the care provided. They told us "They also hold reviews to find out how we are getting on." Relatives were also involved in how the care was provided to people. One relative told us " Yes there are some care plans and I was asked to contribute." Records showed people and their families had been involved in the writing of the care plans.

We observed examples of staff supporting people's privacy and dignity for example by knocking on doors before entering rooms and ensuring that doors were closed when personal care was given. We also observed staff talking to people in a respectful way. For example, bending down to people's eye level and speaking discretely to people.

Good

Is the service responsive?

Our findings

People told us there was a range of activities they could participate in including exercises, outings to the garden centre, and singing. We saw some photographs of people engaged in activities displayed in a corridor at the home. We observed that two activities workers facilitated activities in the home. Some people chose to stay in their rooms during the day. One visitor told us they thought there should be more activities on offer to people. We discussed this with the manager. They told us they were aware that whilst people chose to remain in their rooms, this placed them at risk of social isolation. In order to improve the situation for people they planned to increase the amount of social contact people could access by involving social care students from the local college. Their intention was to encourage visits to people to carry out activities they enjoyed or simply to have a chat.

We observed one person who had access to a greenhouse to carry out gardening. This was something they had enjoyed before moving into the home, and the provider had made it possible for them to continue with this hobby. At the end of the morning, they returned from the greenhouse with a hand full of tomatoes they had grown. They appeared very happy with their results. Another person had two cats living with them. These pets were important to the person and as a result the provider had accommodated them.

Care plans were informative and it was evident they had been updated recently. They were clear, comprehensive and had been reviewed. The records of care included sections on mental capacity, medication, mobility, nutrition, continence, hygiene, skin integrity, psychological needs/sleep and communication. Further sections e.g. behaviour were added if needed. We saw in a care plan that a 'Do not attempt cardiopulmonary resuscitation' (DNR) order was in place for a person who did not have capacity. We noted this had been discussed with the person's relative and signed by a doctor. Staff told us the care plans reflected people's changing needs and included information on any special requirements. They said they were kept informed of changes in people's needs at shift handover and daily 'flash' meetings at 11am each day.

We noted a personalised document entitled 'My Life' that contained information such as 'how to support me', 'what's important' and 'life history'. This was kept in the person's room folder. This meant staff could read about the person and their histories prior to coming to the home, the records also documented people's likes and dislikes.

Regular checks were carried out on people and staff documented when these had taken place. Some examples included repositioning charts, hourly observation charts and fluid intake charts. We saw that on the whole these had been updated and regularly recorded. The nursing staff checked the records to ensure each person has received the care they required, they signed to show this task had been completed.

The provider kept a complaints log, this was to ensure complaints were recorded, acted upon and where appropriate learnt from. We looked at the record of one complaint received since the last inspection. This had been investigated by the previous manager but no outcome had been recorded. One person told us they knew how to complain, they said they would complain to staff and expect them to follow this up. Senior managers kept an oversight of complaints to ensure patterns could be explored and action plans followed through. People and their relatives were also able to feedback concerns or complaints at the relatives meetings. These were regular meetings held to discuss events within the home. The last meeting was held to introduce the new manager. We could see a number of concerns had been raised and these had since been dealt with. For example, a second activity person had been employed.

One visitor told us they felt the new manager had an open door policy and that when concerns had been raised these had not been "swept under the carpet" but they had been listened to and it had been recorded.

Good

Is the service well-led?

Our findings

People told us they found the management of the home approachable and friendly. One person told us "The new one is very good and approachable; you can make requests and be listened to." This was the opinion of the people we spoke with. The manager told us they were practical in their approach and when they felt it was needed were "hands on." People in the home had noticed this; one person said "The manager is good; she always comes to see how I am getting on." Another comment included "Oh they are good … the manager always stops to say hi to me."

Staff told us they felt supported by the manager. One staff member described the manager as "Approachable" "Wonderful" and "Will assist". They added that "Everything's come quite a long way now (the manager) is here as permanent." Another staff member told us the manager was "good, really nice" "will help us" (with care).

Staff told us they felt they could go to the manager or nurse with any concerns and that there was a confidential 'whistleblowing' telephone number they could call.

One concern raised by the relatives and visitors was the lack of consistent management in the home. A number of changes of managers had taken place over recent months. It was apparent to us, the new manager had in the short time they had been working in the home identified some areas of improvement and acted on others. It was also evident the areas requiring improvement identified through our inspection had not been overseen due to a lack of consistent management. We were assured by the manager these things would be improved upon.

The home continually sought feedback from people who lived in the home, staff, relatives and professionals. The provider had a software package which was linked to an I pad which was available to use at all times in the reception hall. Specific questions were asked and people could answer honestly about their views of the service on offer at Chiltern Court Care Home. The information is escalated to the regional manager who looks at where improvements can be made. This is then discussed with the home manager to put together an action plan of improvements.

A number of audits took place at the home. Each day the manager undertook a daily walk about of the home. During this they answered 10 questions about environment, staff and people in the home. Any areas requiring improvement were planned and carried out, records verified this. For example during one audit it was observed that a person's hair did not look well cared for, an appointment was made with the hairdresser for this to be rectified.

Every week one person's care file was audited. This was to ensure the contents were correct and accurate. Where amendments were needed this was relayed to the staff. Audits were also undertaken to ensure people's needs were being met, this included looking at clinical indicators such as weight loss and infections. Where concerns were raised or there was evidence of deteriorated health, relevant professionals were referred to. All audits were overseen by the regional manager. If an audit had not been completed these were flagged up on the regional manager's tracker and appropriate action was taken to ensure compliance.

The manager was in the process of identifying staff as "Champions" for different areas of care within the home. This was based on the interests of the staff members. There would be one or two champions for area, this would include: end of life care and medicines. Nutrition and diabetes, safeguarding and infection control. The manager had identified the staff members and was in the process of arranging specific training, which would enable each champion to guide staff in good practice in each area.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People who use services and others were not protected against the risks associated with unsafe or unsuitable practice because of inadequate staff training and supervision. Regulation 18 (2) (a)(b)(c)