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Chimera Rest Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 17 and 19 August 2016. Two inspectors visited the service on both days of the inspection.

Chimera is registered to provide accommodation and support for up to seven people. On the first day of the inspection the provider told us that six people lived at the home. On the second day of the inspection the provider told us that one person who lived at the home as a lodger had become a resident during the inspection.

At the last inspection we found that people were not safely supported because care was not planned in a way that met peoples' needs or provided in a safe way, medicines were not safely managed, recruitment was not robust and there were not effective governance systems in place.

At this inspection we found three repeated breaches of the regulations and four new breaches of the regulations.

In particular, we identified the delivery of care posed risks to people, the management and administration of medicines was not consistently safe and recruitment checks were not always completed in accordance with current legislation.

Staff told us they were supported but training records showed some staff had not received adequate training to make sure people's needs were met. In addition staff were not working in accordance with the principles of the Mental Capacity Act 2005 and whilst people had been supported to see their GP, nobody living at the home had seen a dentist.

People told us staff were caring and friendly and a member of staff said, "The residents are looked after really well". Another member of staff told us, "The care is really good here".

People told us that staff responded to their requests for support promptly. People's needs had been assessed and there were care plans in place to meet their needs, however, there was limited evidence that people were supported to engage in meaningful activities.

The governance systems in place did not ensure people's needs were safely and effectively met.

CQC is now considering the appropriate regulatory response to the shortfalls we found. Where providers are not meeting the fundamental standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

People were not kept safe at the home.

Risks to people were not managed to make sure they received the correct care they needed.

The management and administration of medicines was not consistently safe.

Recruitment checks were not always completed in accordance with current legislation.

Is the service effective?

Requires Improvement

The home was not fully effective.

Staff told us they were supported but records did not evidence all staff had received the training they required to deliver care according to people's needs.

The home required improvement to ensure staff adhered to the principles of the Mental Capacity Act 2005.

People had been supported to see their GP or nurse when required but nobody who lived at the home had received dental support in the last 18 months.

Is the service caring?

Requires Improvement

The service was caring but needed some improvement. This was because written information did not always respect some people's dignity.

People told us staff were kind and caring.

Staff were fond of the people they were caring for.

Is the service responsive?

Requires Improvement

People told us that staff responded to their needs promptly.

People's needs were assessed and care was planned for.

There was limited evidence that people were supported to engage in meaningful activities.

Is the service well-led?

Inadequate

The service was not well led.

The culture at the home was reactive rather than proactive.

The provider had failed to display their last inspection rating as required by the regulation.

There were ineffective governance systems in place and we could not be sure people received safe, effective care.

Chimera Rest Home

Detailed findings

Background to this inspection

This unannounced inspection took place on 17 and 19 August 2016. Two inspectors visited the service on both days of the 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.

As part of the inspection we spoke with five people who lived at the home and met and spoke briefly with two other people. We looked at three people's care, treatment and support records in full, and sampled specific care records for most of the people who lived at the home. We also looked at records relating to the management of the service including staffing rotas, staff recruitment, appraisal and training records, accident and incident records, premises maintenance records, staff meeting minutes and medicine administration records.

We spoke with the provider and also talked with four other members of the staff team.

Before our inspection, we reviewed the information we held about the service. We also looked at information about incidents the provider had notified us of, and requested information from the local authority.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living at the home however; we identified areas of concern that meant people were not fully protected from the risk of harm.

At the last inspection we identified a breach in the regulations because people were not protected through the safe management of medicines. At this inspection we found a continued breach of this regulation.

Medicines were not always safely managed or administered. All the people who lived at the home were supported by staff to take their prescribed medicines and we found that Medication Administration Records (MAR) were completed. Some medicines were stored in a fridge and daily temperatures were taken to make sure the fridge was working effectively. However, staff had not been provided with guidance and appropriate minimum and maximum fridge temperatures. This meant there was a risk that people's medicines may have been stored at the wrong temperature and which could lead to the medicine being less effective. Some people required prescribed creams and records showed these had been administered. However, staff did not have guidance such as cream body maps to enable them to understand what the cream was for and how to apply it.

Records showed that some staff had been trained to administer medicines; however, no staff had received a medication competency assessment to ensure that they could safely administer medicines.

Staff had administered a suppository to one person who was experiencing constipation. We asked the provider about the training staff had received to undertake this task. Initially they told us that this was contained in the general medicines management training some care staff had received. They then advised us that they had trained the staff member including observing the insertion of the suppository. We received conflicting information from the care staff who had been on duty that day about whether this task had been undertaken by two care workers, or by one care worker and the registered provider. There was no training recorded for either care worker. There was no care plan for the person that provided guidance on this task. This posed a risk that this person's care may not have been delivered safely.

Risks to people were assessed for areas such as falls and pressure care. However, the delivery of care posed risks for some people.

On the first day of the inspection we found that four people had specialist pressure care mattresses. Three of the four people's mattresses were set incorrectly. This meant they were not working effectively and posed a risk to people's skin integrity. On the second day of the inspection we found that mattresses were set correctly.

In addition, one person required use of a hoist to enable them to move from their bed to a chair safely. We saw that they were sat in a chair on their hoist sling. We asked staff and they told us the sling was not one that was suitable for people to sit on. We discussed this with the provider who advised they had ordered some new slings that were suitable. On the second day of the inspection we noted this person's sling was

not in situ when they were sat in their chair.

Some people required fluid monitoring to ensure they remained hydrated. The fluid monitoring records did not contain targets for fluid consumption or totals for the amount of fluid consumed. This meant there was a risk staff would not recognise or take action should someone not have enough to drink.

One person required oxygen and we asked the provider about how the equipment was maintained. They told us the equipment was maintained by an external organisation. However, records showed staff had been advised by a health care professional reviewing this person's oxygen treatment that they needed to clean the oxygen filters on a weekly basis. The provider was unaware of this until we brought it to their attention. This placed the person at risk because the filters had not been cleaned regularly

This was a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there were on-going risks that people had not received safe care and treatment.

At the last inspection we found people had not been fully protected from the risk of unsuitable staff being employed as recruitment practices had not been followed. At this inspection we found continued shortfalls in staff recruitment. Of the six staff recruitment files we reviewed two staff had been recruited safely and in accordance with the regulation. One staff member did not have a Disclosure and Barring Service (DBS) record to confirm they were suitable to work in a care home. Another staff member's DBS identified an area of risk, but there was no risk assessment to demonstrate how this risk had been considered. A further member of staff did not have identity checks in place and the sixth staff member did not have a recruitment file meaning we were unable to check their suitability.

This was a repeated breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not adhere to the legislation that ensure staff employed are suitable to work with vulnerable adults.

The provider had made some checks to ensure their environment was safe. For example, fire safety checks were undertaken and equipment such as hoists and the stair lift had been serviced. Other equipment such as the gas boiler had also been serviced. In addition the provider kept a record of maintenance and repairs carried out at the home.

There was information on keeping safe displayed in communal areas of the home. Staff had received some training on the protection of adults.

Accidents and incidents were recorded for people. These had been analysed to help staff to identify trends or patterns.

Requires Improvement

Is the service effective?

Our findings

People spoke positively about care staff. We received comments which included, "They take really good care of me here, they do a good job, they work hard" and, "They're pretty good".

Staff told us they had received an induction when they started working at the home. The provider told us they had signed all staff up to a care certificate course (this is the nationally recognised care induction). Some staff had received training in a number of areas over a two day period. The two day training covered medicines, health and safety, infection control, food hygiene, manual handling, fire, basic life support and first aid, dementia, the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards. However, we identified areas of practice including the management of medicines and the MCA that showed the training had not equipped staff with the skills to fully undertake their role. In addition three members of staff whose files we looked at did not have evidence that they had attended the above training.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because all staff did not have the skills and training necessary to carry out their duties effectively.

Staff told us they felt supported one said it was, "Nice to come to work and feel appreciated". Staff records showed four of the six staff had received supervision (one to one meeting) with their line manager. Three of the six staff had no record of an annual appraisal. This was an area of improvement identified at the last inspection. This remains an area of improvement for the service.

Consent to care and treatment was not sought in line with legislation 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.

Some people who lived at the home had mental capacity to make their own decisions. We talked with them and they told us staff listened to the choices they made and acted upon them. However, one person who lived at the home did not have mental capacity to make specific decisions. On the first day of the inspection the provider confirmed they had not completed any mental capacity assessments for this person. They confirmed staff were making daily decisions for the individual but none of their decisions had been carried out in adherence to the best interests statutory checklist. The provider told us this was because the person was not refusing any care. In addition, staff told us they sometimes covertly administered a specific medicine for this person. Medicine is given covertly when it is disguised in food or a drink. There was no best interests decision for this action, or a record that this had been discussed and agreed with the person's GP. This meant the person was at risk of not having their rights protected under the Mental Capacity Act 2005. On the second day of the inspection we found two decisions recorded as best interests decisions dated 18 August 2016 for this person. Neither decision had a mental capacity assessment. In addition, neither decision had been carried in accordance with the statutory best interests checklist.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014 because the Mental Capacity Act 2005 had not been adhered to.

Some people who lived at the home had delegated specific decision making powers to other people through lasting powers of attorney. These powers covered both health and financial decisions. The provider told us they were aware of the lasting powers of attorney in place but had not seen them. This meant they could not be sure what powers had been donated by the individual. This was an area for improvement.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). These safeguards can only be used when there is no other way of supporting a person safely. The responsibility for applying to authorise a deprivation of liberty rested with the provider. The provider told us they had made one DoLS application for which they were awaiting the outcome of the assessment.

People told us that meals were adequate and the menu showed there were alternative options if someone did not want what was on the menu.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. Records showed people had seen their GP or nurse when this was required and that staff recognised when people may need medical support and sought help appropriately. People had also been regularly supported with chiropody care. We requested information about people's dental care. The provider told us that no one who lived at the home had received dental care in either 2015 or 2016. They told us that this was because nobody who lived at the home was willing to pay for it. Records did not evidence that people had been offered access to dental care but had declined this. This is an area for improvement.

Requires Improvement

Is the service caring?

Our findings

People told us staff were caring. Staff told us that Chimera Rest Home was, "Family orientated".

There were positive interactions between care workers and the people they were supporting. Observations showed that care workers had a genuine interest in people and their welfare. Staff knew people well and were able to tell us about the people whose care plans we looked at.

Where people had specific information in their care plans such as feeling the cold, we saw staff had supported them in accordance with their plan, for example one person was covered by a blanket as recorded in their care plan.

However, written records were not always completed in a way that upheld people's dignity. For example, one person's care plan said, '[The person] can be very stubborn' and another person's daily record said, '[The person] very rude and violent this morning'. A third person's plan said, 'needs all help with personal hygiene. If you sing and let her join in she forgets to fight you'. In addition, personal information about people was publicly displayed in a communal area. This contained information about individual people such as, 'can be difficult in mood'.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because written information did not ensure that people were treated with respect and dignity at all times.

Requires Improvement

Is the service responsive?

Our findings

People told us that staff responded to their request for help or support promptly.

People's needs were assessed before they came to live at the home. This was to make sure staff understood their needs and were confident they could meet them.

People's assessment information helped staff develop care plans about how someone wanted or needed to be supported. Care plans covered a variety of needs including skin integrity, nutrition and hydration, continence, cognition and sleep. Some care plans were brief but provide staff with guidance about what help or support the person needed. Some care plans were more person centred. For example, one person had a plan about their night-time comfort. This included what pillows they liked, their preferred drink and the time they liked to go to bed. This information would have supported staff to care for the person in an individualised way.

Care plans were regularly reviewed and changes were made where these were required to make sure staff had up to date guidance about how people wanted or needed to be supported.

Staff also completed daily records. These provided staff with information about how the person had been during the day including what they eaten and drank and what personal care support they had received.

The provider showed us the activities timetable which included a mixture of both in-house activities and going out to places like a local social club for drinks or going line dancing. We asked people about what they were supported to do during the daytime. One person told us there was not much going on, they said there was, "No entertainment". We asked staff what people had been supported to spend their time doing during the week of the inspection. They told us that for three days people had watched the Olympics, prior to that people had an activity of watching sports. They said people were also supported to do a word search, artwork or look at photographs. We asked if anyone had gone out during the week of the inspection and they confirmed this had not happened. The daily records for the previous month showed for one person that they had watched television and been visited by family members. Another person's records showed they had completed word searches, been visited by family and had watched television. There was not a range of activities people could be involved in to meaningfully occupy their time. This had been identified as an area of improvement at the last inspection and remains an area for improvement.

Information about making a complaint was displayed in a communal area of the home. The provider told us there had not been any concerns or complaints raised about the service since approximately 2008-2009.

Inadequate

Is the service well-led?

Our findings

People told us there was a small staff team who worked hard to support people. Our observations showed staff knew people well and staff described a family orientated culture.

Feedback from people had been gathered through the use of quality assurance questionnaires.

In October 2015 we asked the provider to tell us about their plans to improve the service with a view to ensuring people health and welfare needs were met. This is called a Provider Information return. This provider sent us a very brief response. For example, we asked the provider what they did to ensure the service was well-led. Their written response was, 'Lead myself'. We also asked the provider to tell us about the improvements they planned to introduce in the next 12 months to make the service better led, and how these would be introduced. The provider's written response was 'Keep myself fully updated'. We asked the provider what they did to ensure the service was caring. Their written response included 'Train staff effectively'.

However, at this inspection we found ineffective quality assurance and governance systems that showed the provider had not undertaken steps to ensure people received a safe, effective, caring and responsive service.

In addition to this, following the last inspection we asked the provider to write to us and tell us what they planned to do in relation to breaches identified at the December 2015 inspection. We did not receive a response until we contacted the provider with a second request. We received a response in July 2016. The provider told us, 'All the care and treatment meets the client's needs'. However, we found aspects of care and support that were unsafe and ineffective. Some concerns we identified were repeated from the last inspection.

At the December 2015 inspection the provider was in breach of four regulations. At this inspection they had continued to breach three of these regulations and were in breach of four further regulations. The provider is responsible for meeting the regulations. The provider had not taken account of, or fully acted upon the required improvements identified during the December 2015 inspection.

At this inspection we found the culture at the home was reactive rather than proactive including the mitigation of risk. These included areas such as pressure care, medicines management and recruitment where the provider did not identify shortfalls independently, but responded to some of the issues identified during the inspection.

In addition, at the last inspection in December 2015 the provider told us they completed audits to monitor the quality of service but they were not able to produce any evidence of these audits. At this inspection we found again that the governance systems in place were not effective. For example, there was no evidence that audits in key areas such as infection control or care planning. The provider sent us a medicines audit.

However, the audit was not robust and had not identified the shortfalls we found in the medicine management system during our inspection. This meant that the systems and processes and processes in place had failed to assess, monitor and improve the quality and safety of the service provided.

We also requested evidence that a lodger had a Disclosure and Barring Service (DBS) record to confirm they were suitable to live with vulnerable adults. The provider said they could not find one. They had not taken action to assess, monitor and mitigate any risks posed to people from others living at the care home.

People's records were stored securely, however confidential information was on public display which meant the systems in place did not ensure people's confidentiality was upheld.

Providers are required to submit notifications of absence, changes, deaths and other incidents to the Care Quality Commission. We noted there had been one recent death which had not been notified to the Commission.

These shortfalls were a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to ensure effective audit and governance systems were established and implemented.

Chimera Rest Home was last inspected in December 2015 where it received an overall rating of requires improvement, with four areas assessed as requires improvement and one area as Inadequate. To enable people to make decisions about care services the CQC rating must be displayed. At this inspection we found the rating had not been displayed in either the home or the provider's landing page of their website.

This was a breach of Regulation 20a of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the inspection rating was not displayed.

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 10 HSCA RA Regulations 2014 Dignity and respect care and treatment was not always provided in a way that ensured people's privacy and dignity was upheld.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Staff did not ensure people's rights were protected because they were not acting in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider had not displayed the December 2015 inspection rating.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Some staff had not received the training required to enable them to safely meet people's needs.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were not effective systems in place to assess and monitor the quality of care people received.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured staff employed were suitable to work with vulnerable people.

The enforcement action we took:

Warning Notice