London Residential Healthcare Limited

# Chestnut House Nursing Home

## Inspection report

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Date of inspection visit:
09 September 2020

Date of publication:
07 January 2021

## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

About the service

Chestnut House Nursing Home is a residential care home providing personal and nursing care up to 85 people. At the time of the inspection there were 29 people living at the service, the majority of whom were older people living with dementia.

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

The service was not well- led. The providers did not have effective governance systems in place to maintain continuous improvement. The service has not been well-led for five consecutive inspections. This resulted in some people not receiving safe and good quality care. The instability in the management of the service was impacting on the morale of people, relatives and staff.

There were safeguarding systems and procedures in place and staff knew how to report any allegations of abuse. However, some staff told us that some concerns were not responded to robustly and appropriately by line managers. This meant people were potentially at risk because some allegations of abuse were not reported to safeguarding authorities.

Risks were not fully assessed or managed to minimise the risks to some people. This was of concern at previous inspections and had not been fully addressed. Those people particularly at risk were those who needed staff support and monitoring with food and fluids.

People did not receive personalised care and support.  People did not have access to the activities, occupation and stimulation they needed to live fulfilled lives. This had been identified as a concern at the previous inspection and people's emotional well being was still not being met. People's relationships with their family members were not consistently maintained throughout the pandemic.

There was a small stable core of staff that people and relatives spoke highly of. However, there has continued to be a high turnover of staff. Staff retention and turnover has been an ongoing concern at the service. This has impacted on people as they were supported by new staff who did not know them well. Staff did not have enough time to deliver activities, emotional care and support to people.

We were assured the service were following safe infection prevention and control procedures to keep people safe. The service had ongoing monitoring arrangements to ensure all aspects of infection control followed best practice guidance. However, the audits in place did not cover the current pandemic. The service completed a Covid 19 audit following the inspection visit.

There were improvements in the recruitment of staff or in the management and investigation of complaints.

Staff were caring and sensitively supported people to eat and drink. Overall, relatives told us they were happy with the care their family members received and they were kept up to date about important changes in people's physical health. There was an increase in positive compliments and on line reviews.

Rating at last inspection and update

The last rating for this service was Requires Improvement (published 29 January 2020). The provider had conditions of registration varied and they were required to submit to the commission a monthly improvement plan based on the audits they completed.

At this inspection enough improvement had not been sustained and the provider was still in breach of regulations. The service is now rated Inadequate.

This service has now been rated either requires improvement or inadequate for seven of the eight inspections since 2016.

Why we inspected

We carried out an unannounced comprehensive inspection of this service on 8 August 2019. Seven breaches of legal requirements were found.

We undertook this focused inspection to check whether the service was meeting legal requirements. This report only covers our findings in relation to the Key Questions Safe, Responsive and Well-led which contain those requirements.

Our report is based on the findings in those areas at this inspection. The ratings from the previous comprehensive inspection for the Effective and Caring key questions were not looked at on this occasion.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Chestnut House Nursing 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.

The information about CQC's regulatory response to the more serious concerns found during the inspection have been added to the report. We imposed additional conditions of registration to ensure compliance with the regulations.

Follow up

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This

means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

We will continue to monitor information we receive about the service until we 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?**

Inadequate

The service was not safe.

Details are in our safe findings below.

**Is the service responsive?**

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

**Is the service well-led?**

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

# Chestnut House Nursing Home

**Detailed findings**

## Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act.

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 who visited the service and one inspector who spoke with the provider's representatives, staff and relatives remotely

Chestnut House Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or 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

This inspection was announced. We announced the inspection 48 hours before we visited to discuss the safety of people, staff and inspectors with reference to Covid 19.

We requested information about the service to be sent to us when we announced the inspection. This was so the inspector could review documentation and speak with relatives during the inspection site visit.

What we did before the inspection-

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and commissioners who work with the service. 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 met six people who used the service and spoke with them about their experience of the care provided. We spoke with one relative who was visiting their family member. We spoke with 11 members of staff including the regional manager, head of care, nursing staff, care workers and maintenance and housekeeping staff. 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 four people's care records and two people's medication records. We looked at two staff files in relation to recruitment.

We held a telephone meeting with the provider's regional manager and group head of human resources.

During and following the inspection we spoke with eight relatives by telephone and received feedback from a further two relatives via our national contact centre.

After the inspection

We spoke with two staff members and received email and website feedback from nine staff. We continued to seek clarification from the provider to validate evidence found. We looked at a variety of records relating to the management of the service, staff meeting minutes, people's care records and care plans, training data and quality assurance records. We received feedback from two professionals who regularly visit the service.

We continued to review the information we received from the service until 21 September 2020.

Inadequate

# 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 Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- There was some overall improvement in people's risk management. However, risks were not consistently assessed and managed. Risk assessments and associated care plans were not in place for some people. This was identified at the last two inspections.
- There was a lack of oversight in the management of risk. For example, although monitoring charts were completed by staff, no one checked each day. This meant people were at increased risk because prompt action was not taken in response to any concerns identified.
- People's risk management monitoring records were incomplete. For example, people's food and fluid records were not completed as determined by the document template. They did not show how or who had reviewed the person's food and fluid intake each day and if any action was required. This information was then not always shared with staff on handover and daily briefing meetings so they could support the person to drink more
- GP and dietician advice was sought when people had lost weight. However, risk management plans put in place were not always followed. For example, one person's care plan showed they were prescribed nutritional supplements to be given twice a day. In addition, staff were instructed to offer the person snacks in between meals. The records showed that the person was not being offered alternatives or snacks when they had refused to eat the foods offered. The person's poor nutritional and fluid intake was not captured in the handover records. This meant staff were not aware of the need to further encourage this person to eat and drink.
- One person was at risk of developing urinary tract infections (UTI). Although staff were aware of this risk, there was no risk management plan in place to minimise the risks. Records showed and staff were not seen to be encouraging the person to drink, and monitoring the records daily to ensure staff could refer them for medical attention when needed.
- One person's nutrition care plan included their lack of interest in food. However, this person's food records included three consecutive days where they had not eaten and declined food. This was not identified on the handover records until the third day of the person not eating. This meant there was a delay before staff took action to clinically review the person and seek advice. This person had lost a significant amount of weight over a six month period.
- There was mixed feedback from staff as to whether they had up to date, accurate information about the

management of people's risks. For example, some staff told us they did not have time to read people's care plans and they were reliant on information shared at handovers and on handover sheets. However, handover sheets did not consistently include information important about risks to people, such as the need to offer additional food and fluids or their total daily fluid intake.

This demonstrates an ongoing breach of Regulation 12 Safe care and Treatment of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. This was the fifth inspection since 2017 where this regulation was in breach.

● At our last inspection the day to day maintenance was not always effective. This was because repairs to people's bedrooms were not always completed or followed up. At this inspection, improvements had been made in the systems for managing the maintenance in the service. Equipment, such as lifts, and hoists were checked by external contractors to ensure their safety.

Staffing

At our last inspection, the shortfalls in staffing and staff skills and knowledge were a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● The number of people living in the home since our last inspection had reduced and staffing levels had also changed. Prior to the inspection, following concerns being raised about staffing levels in the home at night, we asked the provider to send us information about staffing. The provider told us prior to the inspection and during they were assured they had sufficient staffing to meet people's needs. They told us that the staffing levels provided were higher than needed when reviewed against peoples' dependency.
● There remained a core of nursing and care staff at the service. However, there also continued to be a high staff turnover at the service. This included managers, live in agency staff and staff employed by the provider.
● Where staff were inexperienced or unfamiliar with people' needs, this was having a negative impact on people's quality of care and creating increased risk. For example, staff told us they did not have time to read all the information about people so they could provide personalised care.
● One person told us, "the good ones move on to pastures new. I wish they (managers) would appreciate the staff they have as they work very hard. If they listened to staff they might not leave."
● There was a risk that people may not receive support to ensure their emotional, occupation and social needs were met. For example, staff consistently fed back there was not enough time to deliver activities, emotional care and support to people. This meant there were long periods of time where people not supported to engage with others and did not have the opportunity to be stimulated and be occupied. People who were living with dementia were quiet and withdrawn and spent long periods of time with no stimulation either in their bedrooms or in communal areas. Records showed that some people spent long periods of time alone, or in bed with the provision of personal or nursing care being the only staff interaction they had.
● The management team told us they had reviewed the staff induction programme and staff had a two week induction programme that included shadowing experienced staff.
● There were mixed views about the quality of the induction programme. Some staff spoke highly of the training and support they had received whilst other staff told us their induction had not prepared them for working with or knowing enough about the people living at the service to be able to provide safe care.
● The regional manager acknowledged that staff meetings had not been regularly taking place during the pandemic.

This was the fourth inspection since 2017 where there was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Additional staff had been recruited and were due to start work in the next two weeks. The provider's representatives were confident that the new induction programme in place were provide staff with the skills they needed. Staff had access to online training and there were improvements in the numbers of staff completing essential and core training. Some of the more specialist face to face training had been put on hold because of the pandemic but alternative ways of providing the training were being explored.

Systems and processes to safeguard people from the risk of abuse

At our last inspection, the provider failed to protect people from abuse and this was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff understood their role in protecting people from abuse. Some but not all staff said they had confidence in the management team to take action and keep people safe. Some staff told us when they raised safeguarding or practice concerns with line managers these were not acted on. We raised safeguarding alerts with the local authority, who following the investigation made recommendations in relation to one person.
● The provider had made improvements in the monitoring and oversight of the safeguarding systems at the service. This included a monthly review of any safeguarding incidents.
● The head of care was having regular discussions with the safeguarding team to establish what concerns met the safeguarding threshold.

Overall, improvements had been made the provider was no longer in breach of regulation 13. However, this remains an area for improvement.

Staff recruitment

At our last inspection there were shortfalls in in staff recruitment procedures and this was a breach of Regulation 19 (Fit and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Improvements had been made the provider was no longer in breach of regulation 19.

● Staff were safely recruited and appropriate checks were carried out such as checks with the Disclosure and Barring Service (DBS). The DBS check ensures people barred from working with certain groups such as vulnerable adults would be identified.
● Information relating to the suitability of agency staff who lived on site at the home was available at this inspection.

Learning lessons when things go wrong
● There were systems in place to ensure accidents, safeguarding and incidents were recorded, investigated and action taken. The management team told us they shared any learning through the daily briefing meetings and handover records. However, staff were not clear as to how lessons shared were learnt following incidents/accidents/safeguarding.

Using medicines safely

- Medicines were being safely managed. The head of care oversaw the medicines at the home.
- Staff interacted well with people when they were administering medicines, explaining what the medicines were and staying with them until taken. There was clear guidance for staff about how people liked to receive their medicines.
- There were suitable arrangements for receiving, storing and disposal of medicines, including medicines requiring extra security. Staff recorded a running total of medicines in boxes to ensure there were clear accurate records
- The Medicine Administration Records (MAR) were well completed which meant we were assured medicines had been administered.
- There were protocols in place for administering PRN (as required) medicines.
- Staff completed undertook regular medicine audits and took action to follow up areas for improvement.

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 meeting shielding and social distancing rules.
- 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 accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.
- We discussed with the management team that the infection control audits they had completed did not take into account the current covid 19 pandemic. They showed us a covid 19 audit template which they said they would complete. This was completed following the inspection.

- People lived in a home which was clean and free from odours. Housekeeping staff were clear about the cleaning routine required to help ensure these standards were maintained
- Because of the covid 19 pandemic staff were seen wearing masks and had access to gloves and aprons when providing personal care. This helped to protect people from the risk of an infection.
- Because of an increased risk to people during the Covid 19 pandemic CQC have been using a new Emergency support framework (ESF) to assess infection control measures at care settings. We undertook an ESF assessment with the manager on 14 May 2020 and found they were managing.

Requires Improvement

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them,

At the last inspection the shortfalls in the planning and delivery of person-centred care was a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

- People's histories, interests and what was important to them was not always used to provide personalised care and support. This was identified at the last inspection.
- People who spent time in their rooms, as well as those who were living with dementia and were more reliant on staff to meet their needs, were at increased risk of social isolation. Some people living with dementia were quiet and withdrawn. Overall, staff were observed to be busy and task focused. Some people spent long periods of time with their eyes closed but not asleep and they were not engaged with the music that was playing either in their bedrooms or communal areas.
- There were activities staff employed and there was a programme of group and individual activities. However, activities staff also undertook the drinks rounds twice a day. This was not a personalised approach to supporting people's fluid and nutritional needs.
- The majority of staff told us people did not have access to the activities, occupation and stimulation they needed to live fulfilled lives. This was supported by observations and in people's records that showed low levels of social engagement with staff. For example, one person only had one activity recorded for a whole week and that related to the delivery of a newspaper. Another person's records included that they had two separate sessions of doll therapy over a two week period rather than this therapy being an integral part of their day to day life.
- For those people who were cared for in their bedrooms, their records showed that there were very few episodes each week of staff spending time with them. Some of the records reflected giving people food and drink fluid as an activity. Staff fed back this was because of the high dependency of people so their personal care and support was prioritised over their emotional wellbeing.
- People's care records did not include how the person was each day and how they had spent their time but was focused on the care and support provided. Records showed that some people were spending long periods of time in bed. Some people going as early as early afternoon. This was not reflected as their preference in the care plans. This meant people were spending prolonged periods of time alone in their

bedrooms without company and or any stimulation.

- Relatives told us they had been provided with regular telephone updates as to the changing needs of people during the pandemic. However, video technology was not used to communicate with relatives, so they did not have the opportunity see their family members at the service. Some relatives told us they were reluctant to see their family members who lived with dementia as they felt this would be disruptive and unsettling for them. This view was supported by some staff we spoke with. This meant some relatives were not actively encouraged to make either video or social distanced contacts with people.
- Some relatives told us they had received photographs of their family members at the start of the pandemic and they were pleased with these updates. However, this had not routinely continued.
- Relatives were encouraged by the management team to have garden visits on weekdays rather than weekends. The emails to relatives included that weekend visits could be facilitated but weekdays were preferred. This approach was not personalised, was based on staff availability and not for the benefit of people and or their family members who may have been working during the week.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Most people's communication needs were identified in their care plans. However, these had not been reviewed to take into account how people would be supported with their communication during the pandemic when staff were wearing face masks.

This was the third inspection since 2017 where there was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There were also positive and caring interactions seen between staff and people. People were relaxed and smiling when staff were with them. Staff sensitively supported people to eat and drink during the main meal.
- Overall, relatives told us they were happy with the care their family members received and they were kept up to date about important changes in people's physical health.

Improving care quality in response to complaints or concerns

At our last inspection shortfalls in the monitoring of complaints was a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements had been made the provider was no longer in breach of regulation 16.

- People and relatives knew how to complain or raise concerns.
- There was improved monitoring of complaints by the management team and provider.
- Most staff told us there was no system for receiving feedback from complaints. This meant staff were not aware of complaints, any learning and how practices should be improved. This remains an area for improvement.

End of life care and support

- People had been able to remain at the service for the end of their lives and staff had supported them according to their expressed wishes. People's relatives had been able to visit at the end of their lives during the pandemic.
- Compliments had been received and relatives had praised the care their loves ones had received at the end of their lives.

Inadequate

# 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 deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider had failed to ensure that oversight was effective in improving the safety and quality of the care people received. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements. Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- CQC has taken enforcement action and imposed and varied conditions of registration on the provider for the last two inspections. These conditions included providing CQC with monthly improvement plans. The provider's commitment at the last inspection to continuously improve the quality and safety of the service for people has not been sustained.
- The providers did not have effective governance systems in place to ensure continuous improvement. The service has now not been well-led for five consecutive inspections since 2017.
- Some people did not receive safe and good quality care that met their needs. There were shortfalls in personalised care and in meeting people's emotional, social and wellbeing needs. The lack of fully effective monitoring of peoples nutritional and hydration needs placed them at risk of potential harm.
- Monthly checks on people's care plans did not consistently identify how the risks to some people were being monitored and managed. This meant staff did not have accurate and up to date information on how managed risks and care for people.
- Audits identified shortfalls and areas for improvement, but these actions were not carried forward to the next audit, so records were not updated to show how any shortfalls had been met. For example, the last three months mealtimes audit all included actions to improve people's mealtime experiences and well-being. However, the actions identified were not implemented or carried forward to the next audit.
- People's records and records relating to the governance of the service were not consistently completed. This has been an ongoing shortfall identified during previous inspections. Most people were living with dementia and there were not any regular visitors coming in to the home during the pandemic. This meant people and visitors were not able to tell us their experiences of life at the service and the people's records were relied upon to understand their day to day experiences.
- Some documents provided to CQC as part of the inspection were contradictory and did not always reflect

or correspond with details in people's care and monitoring records. For example, the clinical risk meeting for August 2020 there was differing information in relation to people's weights recorded on peoples records or the service's internal weight monitoring documentations. This meant that some of the information relied on for the governance of the service was not always accurate.

- Since the last inspection there have been multiple management arrangements. The last registered manager left the service at the end of July 2020. Staff fed back that each manager wanted something different and all had different management styles. They felt that as soon as they got used to a manager things then changed. This meant there was not a consistent management approach for people, staff and relatives to drive improvements in the service.
- The head of care was currently responsible for the day to management of the service with support from the regional manager two days a week. This was an interim arrangement until a new registered manager could be appointed.
- The provider's representatives told us they were reviewing the allocation of staff at the service and planned to develop a 'whole home approach' whereby staff worked across the home and undertook a variety of roles. This would require a change on culture for staff and they acknowledged this proposal had unsettled staff.
- The regional manager told us they would be starting monthly sampling of audits from the week following the inspection. This was to ensure actions were followed up. However, routine sampling by the provider had not been happening prior to this.
- The provider's internal compliance team had undertaken a review of the service in June 2020 and an independent external mock inspection had been undertaken in August 2020. The internal review in June 2020 included a number or recommendations, which had not all been implemented. For example, the report recommended that 'Activity Provision to undergo a review and improve activities within the home and maintain the current level of auditing and ensure the audits are a critical review of the service, identify actions from audits and monitor the improvements through the home continuous improvement plan.'
- There was mixed feedback from staff about working at the service. Some staff felt well supported and had confidence in the provider. However, some staff told us the management team and provider did not always listen to their concerns and or act on the information shared. There was low staff morale as a result. One staff member fed back, 'I have raised concerns on several occasions, verbally, and by email, and nothing has come of any of them… Feedback is often not given from the 10@10 meeting (daily briefing) and people who aren't in on the day something is announced, often don't know what's going on.'
- Some staff reported to us that line managers did not act when they raised staff practice concerns with them. We raised these allegations and practice concerns with the local authority. These were investigated with the provider's representative and recommendations for one person were made.
- Staff told us that the constant changes in managers was destabilising as each new manager came in with different ideas and ways of managing the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People and relatives raised concerns with us both about the future of the service and the constantly changing management arrangements. We asked the provider to give people, relatives and staff assurances about the current and future management of the service.
- The provider sent monthly letters and newsletters to people and their relatives. These were focused on the provider's group of homes rather than being specific to Chestnut House Nursing Home. The management team and provider had not provided people and their relatives or representatives with regular assurances about what was happening at Chestnut House Nursing Home during the Coronavirus pandemic.

- The provider's representatives told us they were planning to send surveys to staff, people and relatives to gather their views. Staff surveys had been sent out in early 2020 and identified mixed feedback from the staff team.
- People were reviewed as part of 'resident of the day' programme and the views of their representatives were sought. However, there had not been any formal ways of seeking people's and relative's views during the pandemic.

This was the fifth consecutive inspection where there was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The service had seen a significant increase in positive feedback from relatives both directly and through a care home review website.
- People and relatives also told us although they were unsettled by the frequent changes in the management of the service. They also said they had confidence in the core of staff who had worked at the service for a number of years. One relative said, "The staff and nurses that work there are superb, the staff take on a lot of ownership, but the management has always been unstable."
- Following the inspection feedback, the provider sent us additional supporting documentation and the head of care sent us an updated action plan.

Working in partnership with others

- Health professionals told us they had good working relationships with the service. They fed back that the service did not always make appropriate referrals for people and that staff had not always used their nursing skills to fully assess people before making referrals. This was an area for improvement.

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 9 HSCA RA Regulations 2014 Person-centred care<br><br>There were shortfalls in the planning and delivery of person centred care. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>There were shortfalls in staffing to ensure people's emotional and wellbeing needs were met. |

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<br><br>There were shortfalls in the assessment and management of risks for people. |

**The enforcement action we took:**

We have imposed a condition on the provider's registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>There were shortfalls in assessing and monitoring the quality and safety of the service and in record keeping. |

**The enforcement action we took:**

We have imposed a condition on the provider's registration.