Guide Total Care Group Limited

Chelmer Valley Care Home

Inspection report

Broomfield Grange
Broomfield Hospital Site, Court Road
Chelmsford
Essex
CM1 7ET

Date of inspection visit:
02 August 2018

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10 October 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We previously carried out an unannounced focused inspection of Chelmer Valley Care Home on the 02 May 2018. We carried out this inspection due to significant concerns raised about the safety of people living at the service. These concerns included insufficient staffing, people were not being supported by staff with adequate training and competencies and a lack of effective leadership and oversight of staff at the service. We inspected against two of the five questions we ask about services, is it safe and is it well led. During the inspection we found breaches of Regulation 12, 13, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was rated as inadequate in both domains and was placed in special measures.

Due to the high level of concerns we found, we imposed conditions on the providers registration restricting admissions and requiring the provider demonstrate to us how they would address the failings we had identified.

Following on from our inspection the provider sent us an action plan, which set out what they would do to meet the legal requirements in relation to the breaches and to improve the service.

On 18 June 2018 we undertook a further inspection to check the service had implemented their action plan and establish whether they now met the legal requirements. At this inspection we found whilst there had been some improvements there were still ongoing issues of concern resulting in continued breaches of regulations 12 and 13,17 and 18 and an additional breach of Regulation 5. This meant the rating for the service remained inadequate.

On the 02 August 2018 we carried out a further focused inspection following concerns identified to us by the local authority which included concerns related to staffing, pressure care, people waiting too long for personal care, people being moved without consultation, safeguarding concerns not being reported to the appropriate authorities and medicines management.

We again re- inspected the service against two of the five questions we ask about services: is the service safe and is service the well led. Whilst some improvements were found further improvements were identified resulting in continued breaches of regulation 12, 17 and 5.

Chelmer Valley is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service accommodates up to 140 people in one adapted building across five separate units, each of which have separate adapted facilities. At the time of inspection, the third floor which was designated for use for NHS respite beds was closed to admissions and was empty. People requiring support with dementia nursing needs resided on the ground floor of the building. 26 people were living on the ground floor at the

time of inspection. The first floor of the service was a residential unit. At the time of inspection 16 people were living on the first floor. In total, 42 people were living at the service on the day we inspected.

On the day of the inspection the registered manager was not available. 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.

We were informed by the local authority that they had identified some concerns in relation to failing to report safeguarding concerns, lack of staffing, people being moved to the nursing unit without consultation and medicine management.

Staff had received training in how to safeguard people from the risk of abuse. We discussed the concerns identified by the safeguarding team and the provider told us this had been an oversight and these were subsequently reported.

Prior to the inspection the local authority informed us people were being moved without the appropriate consultation in place. This was because people's needs had increased so they were being moved to the nursing unit. We found appropriate consultation had taken place with people or their representatives.

Prior to the inspection we had received concerns around staff competency in medicine management from external social care professionals. At this inspection we identified the provider had processes in place to manage medicines but found some improvements were required.

At our previous focused inspection in May 2018 we found staff did not have access to the information required to support people who were vulnerable and at risk. During a focused inspection in June 2018 we found some improvements but were still concerned that the overview in care plans was not being updated adequately with information required in relation to risk. At this inspection we found some improvements in terms of risk, however additional improvements were still required.

Concerns were also raised by the local authority with regard to people waiting too long for personal care and assistance with eating and drinking, and staff were not deployed effectively to meet these needs. At this inspection we found staff were deployed effectively to meet people's needs, staff told us staffing had recently increased which had helped.

At our last focused inspection in June 2018 we recommended the provider review it's systems and processes for recording and monitoring the food and fluid intake of people at risk. At this inspection we noted some improvements in this area and that documentation recorded people's intake and output appropriately.

Staff understood the importance of good infection control practices. We observed staff using protective gloves and aprons and actively hand-washing before providing care and support to people to prevent the spread of infection.

Whilst improvements had been made in terms of monitoring the safety and quality of the service, an interim manager was new in post so people that used the service and staff were not clear about the changes to senior staff that had taken place and how this might impact on staff morale and the day to day running of the service.

We have therefore also made a recommendation that the service makes improvements to identify how

people using the service and staff are involved and engaged in the running of the service.

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The provider had independently sourced the services of a crisis management company to take over the day to day leadership of the service. Whilst we noted some improvements had been made we were not assured about the sustainability of these improvements and the service will therefore remain in special measures. We were however assured that the service appeared to be moving in the right direction but required more time to evidence this.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

More work was required to ensure all documentation in relation to risk was accurate and up to date.

Oversight of medicines management required improvement.

There were sufficient staff available to safely meet people's needs.

The service had made some improvements. However, more improvements were necessary to provide an assurance that these were embedded into practice and were sustainable long term.

Is the service well-led?

Inadequate

The service was not well led

Staff continued to feel disengaged and not included in the running of the service.

Progress that had been made to address areas of concern was noted to have stalled and declined at times, although at this inspection improvements were identified within the week prior to inspection.

Governance systems in place to identify and manage risks had not always been affective.

A new independent crisis recovery team was in place and managing the service. They demonstrated a good understanding of how to move the service forward.

Chelmer Valley 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 was 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.

The inspection took place on 02 August 2018 and was unannounced

The inspection team consisted of four inspectors. Before we carried out the inspection we reviewed the action plan that had been submitted by the provider so we could check on the progress made about making the necessary improvements to ensure people's safety.

Before the inspection we had been in contact with a representative from the local authority safeguarding team. They told us about concerns they had identified during their visit.

During our inspection visit we spoke to two visiting relatives. We spoke with 13 staff including senior staff, agency workers and nurses, the quality lead and the nominated individual.

We reviewed nine people's care plans and used this information to case track people's care needs, observing the care they received, checking their daily records and staff knowledge to ensure the care people were receiving matched their assessed needs. We also checked documentation that was relevant to the management of the service including quality assurance and monitoring systems

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in May 2018 we found people were not always protected from the risk of abuse as many staff had not received the required training and therefore lacked knowledge on how to keep people safe from harm. We also found potential safeguarding concerns had not always been identified, reported and investigated appropriately by the provider. At a focused inspection in June 2018 whilst some improvements had been made further concerns were identified in relation to people being at risk of harm which compromised their dignity and wellbeing.

This focused inspection in August 2018 was carried out due to further concerns raised by the local authority in relation to safeguarding incidents not being reported appropriately. These concerns were related to unexplained bruising, people's personal care needs not being met in a timely manner, people not being supported with an appropriate diet, and senior staff not weighing people in line with their care plan. When we spoke to the provider they informed us this had been an oversight on their part and these concerns were reported immediately after the inspection.

Staff we spoke with had a good understanding of the different kinds of potential abuse. They were aware of their role and responsibilities in relation to protecting people and what action they would take if they suspected abuse had occurred within the home. One member of staff said, "I would report straight to the manager and protect the person. I know I can also inform the safeguarding authority and the police if necessary.

At our last inspection in June 2018 the registered provider was not meeting the regulations related to managing risk as up to date information was not always available to staff. At this inspection whilst we saw staff were now provided with up to date handover information, the provider had further work to do to ensure care plans, handover information and pen portraits (a summary at the front of the care plan which briefly highlights relevant needs and risks) were all updated with the correct information. We found there were still some discrepancies which related to relevant information. For example, in one care plan the handover information and care plan included recent information regarding a recent SALT (speech and language therapist) assessment. This assessment stated the person now required thickening powder to be used in all fluid as part of their treatment for dysphagia (swallowing problems). However, this information had not been added to their pen portrait. When we asked staff about this person, staff were able to tell us about this recent update as they had been given the handover document which did contain the most recent information but this was not in the care plan. We also noted not all pen portraits contained a date which meant staff would not know when the information had been recorded.

Visiting health and social care professionals continued to raise concerns to us about a lack of recording by staff about the care received by people who were nursed in bed. This also included concerns that staff were on occasion recording care provided in advance of care received. For example, those who required frequent turning and or with support for fluid and nutrition. The consequence of such practise can mean that people are placed at risk of not receiving timely care and treatment which can result in the development of pressure ulcers and people would be at risk of dehydration.

We carried out a review of these documents throughout the morning for people cared for in their bedrooms, and found that in the majority of cases these were now being filled in appropriately with the current actions taken by staff. However, on the nursing unit we found two discrepancies. For example, staff recording they repositioned a person who was at risk of pressure sores at 11 am, prior to 11 am. It was unclear when the person had actually been repositioned.

We observed one person walking up and down, this person had been identified as posing a risk to others as they could enter other people's rooms and switch off their pressure mattresses. The service had put chains across all doors in the nursing unit as a solution to this problem. Whilst this may have prevented the person from entering others room we felt it potentially may have created an additional risk people may fall over the chain. We could not find any evidence that permission had been sought to use this restrictive solution or put these chains up. We did note some rooms did not have the chain in place, and were just hanging loose. One person where the chain was left unattached was particularly vulnerable as they had a pressure mattress and catheter in place which was on a stand on the floor, both of which could be tampered with by the person walking up and down unsupervised. Therefore, the chain was not an effective measure to manage the risk and people may have been harmed as a result.

The system to manage medicines required improvement. At our last inspection in June 2018 we found there were systems in place to manage people's medicines safely. At this inspection we found one medicine administration record (MAR) was confusing with new medicines recorded on an old chart although signed for, the information was unclear. The nurse immediately re-wrote the MAR. We also noted in one person's room thickening powder was stored on the top of the wardrobe, when we checked this the pharmacy label stated this was for a different person. When we spoke with the nurse we reported this to they were not aware of why this had happened and identified the person did not have any thickening powder in stock and ordered this immediately. We also noted whilst this thickening powder was stored on top of a wardrobe it was still easily accessible and safe storage was not maintained in line with the 'Patient Safety Alert: Thickening Powders' dated 2015.

We checked controlled drugs (CDs). CDs are drugs classified under the Misuse of Drugs Act 1971 and have specific requirements in relation to the storage, administration and recording. We noted one person's pain relief patch had been administered late the nurse had carried out an investigation and completed an incident form and this error was clearly recorded in the controlled drugs register. However, on the day of our inspection we noted another person had received their pain relief patch two days late, there was no incident form or reasons recorded for this. We brought this to the nurse's attention and this was to be investigated immediately. The nurse kept a pain monitoring chart and it was recorded this person had not expressed any signs of pain due to this delay.

We identified the above concerns were a continued breach of Regulation 12; safe care and treatment.

Our previous inspection in May 2018 we identified the provider had failed to ensure sufficient numbers of suitably skilled and competent staff were deployed to safely meet people's needs. We therefore imposed a condition on the provider's registration requiring them to demonstrate that the numbers, skill mix and competency of all staff employed met the assessed needs and managed any risks to people who used the service. At our inspection in June 2018 we identified staffing had improved and at this inspection further improvements were noted.

People, relatives and staff told us they felt there was enough staff to care safely for the people in the home, as the number of people who used the service had decreased recently. One relative said, "We love it. I have no concerns. I am not worried [family member] loves all the girls. I am in here nearly every day. I know when I

am not here [family member] is well looked after and I don't worry. The girls know the routine." A staff member told us, "Levels were increased recently so it does seem enough." Another staff member said, "Lots of good things are starting to happen. I have noticed we have less agency and have our own staff. It's better for residents, because they are getting used to permanent staff. There are four this side and four the other side and two nurses. Before there used to be three on each side but now there is four. This has been in place for the last month or so."

At the time of the inspection, the service was clean. Staff had been trained in the control of infection and food safety and we saw they had access to appropriate personal protective equipment [PPE] such as gloves and aprons.

Inadequate

Is the service well-led?

Our findings

We had previously carried out focused inspections on the service in May 2018 and June 2018. On each occasion the service was rated as inadequate in the well led domain. However, we had begun to find improvements and the service appeared to be on its way to recovering during the inspection in June 2018.

During this inspection a number of recent changes to the management structure had affected the progress made and resulted in some service instability. Whilst initial indications were that the new management structure, which had only been in place for two weeks at the time of this inspection would support improvement, it was too early for the service to demonstrate this. Consequently, we found that the service continues to remain inadequate in this key question with an improving picture.

At the time of inspection, the registered manager was not present at the service. Care staff informed us that they had been distressed by the sudden absence of the registered manager and that the provider had not been open about where the manager had gone. Some care staff told us that they worried about "Who would be next to go," and that there were rumours amongst staff about what was happening at the home. Staff told us, "The [provider] has not been open and honest about what is happening here. We don't know if our jobs are safe." Staff told us this had negativity impacted on their wellbeing. Staff told us, "The registered manager had really taken on board what we needed to improve and was enthusiastic and helpful. I haven't seen them in ages and there are rumours about where they have gone." Care staff poor wellbeing and lack of involvement had been identified as a contributory factor of poor care provided at the inspection in May 2018.

We found the provider continued to insufficiently support and engage staff and this had led to some instability of the service, and contributed to some of the concerns that we had received about the service, resulting in this re-inspection. These concerns are discussed within the safe domain. However, in the week proceeding this inspection the provider had sourced support from a specialist recovery team consisting of health care professionals that support care homes in crisis Care staff told us that this team had been supportive, listening to their concerns and they were beginning to develop trusting relationships with the support team.

We spoke to the recovery team about how they intended to support improvements at the service going forward. We found that they had a good grasp of areas that needed review, however, in discussions we also found that the provider had not fully briefed the team on essential information regarding the current conditions placed on the home in May 2018. These conditions required the provider report to us every week on progress made in relation to our identified areas of concern.

At the previous focused inspection in June 2018 we had concerns that action plans were constantly being changed and timeframes for achieving progress constantly moved. We found that this concern continued and was evidenced by the number of concerns received by the commission from other sources, including health and social care professionals and the public, and the weekly required submissions submitted to the commission by the service.

We identified this to be a continued breach of Regulation 5 of the Health and Social Care Act 2005; 2015.

Governance processes to ensure that the service identified and investigated reportable incidents in line with the regulatory requirements had failed. The recovery team found that the service had not notified the local authority and us of several notifiable concerns. Because of this they were now having to make retrospective referrals and notifications and carry out a number of investigations into those incidents they had highlighted as a concern.

We found that the recovery team were working proactively with the local authority to ensure that these were robustly reviewed. As the recovery team had yet to fully review all the systems in place, we were unable to evidence that governance systems, previously identified as poor, had improved during this inspection.

Whilst the service had been working constantly with the local authority safeguarding team and commissioning team to ensure that improvements were being made, the instability over the management of the service and lack of engagement with staff had hindered the services ability to continue to demonstrate consistent improvement. In some cases where improvements were made, these were sustained for only a short period of time before the same errors were found again by visiting professionals. There had also been a number of changes in the agencies used to deploy staff to any vacant care shifts. This also impacted on improvements that had been made.

This was a continued breach of Regulation 17 Good Governance, Health and Social Care Act, 2008; 2015.

Engagement with people living at the service continued to need improvement, particularly around activities and what was happening at the service. We saw little activity and engagement with people living at the service and staff told us they did not always feel involved and engaged.

However, whilst we have not reviewed the activity and engagement of people at the service thoroughly during this inspection, we recommend that the service ensure that they are able to demonstrate how people using the service are involved and engaged about the running of the service and the day to day engagement and activities.

We had received concerns that people had been moved to different units without their consent due to poor staffing and low numbers of people on one particular unit. However, we found that staff had taken appropriate measures to discuss with people and their loved ones when people were not able to consent to the move. We found that when people had been moved, this had been in line with their health needs and best interests. Whilst documentation had not been completed at the time of the move, staff were able to evidence through retrospective entries and communication with family members, that discussion and agreement had taken place.

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 5 HSCA RA Regulations 2014 Fit and proper persons: directors
Treatment of disease, disorder or injury	The registered provider lacked awareness of their duties and responsibilities to ensure the safety of people living at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People's identified risks were inconsistently managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Governance systems were still not robust enough to evidence any sustainability