

Chantry Court Care Ltd

Chantry Court

Inspection report

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15 November 2019

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service

Chantry Court is a retirement village for older people which has a service to provide people with personal care when their needs for help increase. People could also choose a different provider to support them with personal care. At the time of the inspection 32 people were receiving personal care.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

Each person or couple living at the retirement village had their own flat with a locked front door. There were communal spaces such as a cinema, dining room and lounge area. There was also at least one member of staff awake 24-hours a day to support people with any needs.

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

People felt safe and cared for living at the service. However, improvements were required in several areas. This included medicine management; assessing and mitigating risks; staff recruitment; staff training; and care plans containing up to date information.

Systems to audit the quality and safety of care had not been completed regularly since the middle of 2018 by the management. There was some confusion about the current structure of management from staff spoken with and during the inspection. Although, the provider had started to identify there were issues prior to the inspection by employing a quality improvement member of staff to implement changes.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. However, they were not always being followed. We have made a recommendation about how this could further be improved.

People and staff had mixed opinions about whether there were enough staff. No impact was found to people by current staffing levels and people's calls were on time. During the inspection we saw systems were in place at the village to reduce social isolation.

Staff were kind and caring throughout the inspection. Only positive interactions between people and staff were witnessed. Staff clearly knew the people living in the village well. Staff respected privacy and dignity throughout the inspection.

Links had been developed with other health and social care professionals and plans to continue this were shared. The current management clearly wanted to make improvements and were open during the inspection to how this could be achieved.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection

The last rating for this service was good (published 9 June 2017).

Why we inspected

This was a planned inspection based on the previous rating.

Enforcement

We have identified breaches in relation to medicine management, risk assessments, staff training, staff recruitment and management systems at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up

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?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement ●

Is the service caring?

The service was caring.

Details are in our caring findings below.

Good ●

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-Led findings below.

Requires Improvement ●

Chantry Court

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team

This inspection was carried out by one inspector.

Service and service type

This service is a domiciliary care agency. It provides personal care to people living in their own flats whilst they are living at the retirement village.

Chantry Court provides care and support to people living in a specialist retirement village for older people. The retirement village is purpose-built or adapted single household accommodation in a shared site. The accommodation is bought or rented and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used in the retirement village; this inspection looked at people's personal care and support service if they accessed the domiciliary care agency ran at the retirement village.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. However, at the time of the inspection the registered manager was stepping back from their duties of running the domiciliary care agency to focus on overseeing the retirement village. The head of care was beginning to take on the role of running the domiciliary agency and was planning to register as the manager.

Notice of inspection

We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be present at the domiciliary care agency office in the retirement village to support the inspection.

Inspection activity started on 13 November 2019 and ended on 15 November 2019. We spent time in the main office of the retirement village where the domiciliary care agency ran from on all three days of inspection.

What we did before the inspection

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 looked at other information we held about the service and provider before the inspection visit. We also contacted health and social care professionals who were in regular contact with the service. We used all of this information to plan our inspection.

During the inspection

We spoke with eight people who used the service and observed interactions with staff both in their flats and communal areas of the retirement village. We spoke with the registered manager, head of care and the provider's quality assurance member of staff. We also spoke with five members of staff which included care staff and auxiliary staff.

We looked at three people's care records. We observed care and support in communal areas. We looked at four staff files. We looked at information received in relation to the general running of the service including medication records, auditing systems and environmental files.

After the inspection

The management sent us further information, and some updates on the concerns found on inspection including an action plan. We requested a variety of information including policies and procedures. All this was sent in the time frames given.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- Medicines were not being managed in a way to keep people safe. Administration of medicines and support with medicines was inconsistent. Visit logs contained a range of information about how staff had supported a person. However, no accurate information was given about which medicines had been administered or 'overseen'. Neither were there agreements in place to determine who was responsible for monitoring the stock of each medicine staff were managing.
- People who had medicines 'as required' had no guidance in place to ensure staff were administering them consistently. One person required a pain medicine patch. Staff told us they rotated application of the medicine patch on different parts of the person's body. This had not been recorded so staff knew where to apply a new patch in line with the medicine instructions. This could lead to a skin irritation.
- No risk assessments or agreements had been made with each person or their representatives about how their medicine was going to be stored in their home. One person had medicines which should have been returned months ago which had not. They also had medicines which should be stored with some security because the person and unauthorised people could access them.
- Two people had support with medicines stored in their food fridges. Staff were supporting one of them to prepare their medicines. No agreement had been made about how the staff would ensure it was stored at a safe temperature and was undamaged.
- Two members of staff had completed a tick chart medicine knowledge check. However, no members of staff had a record of their competency being checked by senior staff. One member of staff told us they had never had a senior staff observe they were administering medicines safely since starting work.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate medicines were managed safely. This placed people at risk of potential harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risks to people had not always been considered or ways to mitigate them included in guidance for staff. One person had a special mattress to prevent pressure ulcers. Although current staff were aware of the alarm on the mattress and what to do, there was no guidance in the person's care plan including what setting it should be on to be effective.
- Two people had specific health conditions. There was no information in their care plans to inform staff how to recognise changes in their health. Neither was there information about what action the staff should take. Staff spoken with had a basic knowledge and relied on people telling them how to support them.

Some people were living with dementia which meant their memory was inconsistent.

- Staff were carrying out or supporting people with their specific health conditions with limited training placing the person at potential risk of harm.
- Environmental risk assessments had been completed for each person's visit to identify risks for staff. However, two people had identical risk assessments with gaps. Three people had terminology used in the risk assessment which the head of care and quality assurance had to look up because they did not know what it was. The registered manager gave a different answer to what the term meant. Therefore, risk assessments did not always reflect current risks in the home and had staff who were unaware what some of the risks were.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate risks had been assessed or mitigated to keep people safe from potential harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- During and following the inspection, the quality assurance member of staff and head of care created an action plan of how they were going to rectify these issues.

Staffing and recruitment

- Systems were not in place to ensure staff were safely recruited to work with vulnerable people. Staff files did not always have records of checks which had been completed with previous employers prior to starting work. No risk assessments had been put in place for staff without references from previous employers who were working alone with people.
- Others staff files had no records of reference checks from another employer only a personal reference or criminal record checks prior to starting work. One staff member had a gap in their employment history which had not been explored.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate staff were recruited in line with legislation. This placed people at risk of inappropriate staff working with them. This was a breach of regulation 19 (Fit and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- The provider's quality assurance member of staff had already recognised these issues. They were currently working through an action plan to rectify the missing or incomplete checks. New potential staff were currently going through improved systems.
- People had mixed opinions about whether there were enough staff. Some people felt their calls were answered quickly and visits were on time. Others gave examples where care was not received as promptly as it should be. No evidence was found people's needs were not being met by current staff levels.
- Staff felt there were enough of them to meet people's needs and visits. They all explained they worked together when it was a more difficult day. This included staff swapping who they were visiting to ensure everyone was seen on time.

Systems and processes to safeguard people from the risk of abuse

- People told us they felt safe and staff knew how to keep them safe. One person said, "They [staff] do the best they can". Others told us how staff support them and look after them.
- All staff were aware of how to recognise signs of abuse. They all knew what to do if they were concerned about a person and felt action would be taken. If it was not they knew which external bodies to speak with.

Preventing and controlling infection

- People were supported by staff who had access to equipment to reduce the risk of infections spreading. During visits we saw staff wearing gloves and aprons if they were supporting people with intimate care.

Learning lessons when things go wrong

- Examples were seen that the staff and management had made changes when something went wrong. Although records were not accurately recording the actions taken. Two people were having their visits extended because it had been identified staff did not have enough time to complete all tasks.
- Systems were being developed by the quality assurance member of staff to improve actions being taken when things went wrong.

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff were positive about the training they received. Many told us they had also completed specialist training in health and social care. However, we found staff did not have all the training required for people with specific health conditions such as diabetes and pressure care. Some staff were relying on training they had from previous places of work. Others were relying on experienced staff members showing them what to do.
- Training records were incomplete and did not demonstrate staff had received all the training to meet people's needs and health conditions. Staff had not received the training. Staff lacked detailed understanding about some health conditions people had.
- Not all staff had received end of life training yet one person was receiving end of life care during the inspection. Some staff told us they had received guidance from the visiting district nurses.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate training was delivered in line with people's health needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider's quality assurance staff member had produced a new training matrix. They were working with the head of care to source relevant training which was required.
- New staff completed a variety of shadow shifts with experienced staff. They were positive about this as it helped them to get to know people and their needs well.
- All staff new to care completed the Care Certificate which is a set of standards all health and social care professionals should have.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

- Capacity and consent had not always been considered in line with statutory guidance. For example, one person had a special mat to alert staff when they got out of bed to reduce the risk of falls. Although their relative had been consulted there was no information whether they had the correct authority. No capacity assessment or best interest decision had been recorded in the person's care plan.
- Staff told us they would always seek consent before supporting someone with a task. However, minimal work had been done to consider people with fluctuating capacity in line with statutory guidance. For example, one person had

We recommend that the provider considers current guidance on capacity and consent and takes action to update their practice accordingly.

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

- Care was not always being delivered or assessed in line with current standards, guidance and the law. Their medicine needs had not been assessed in line with current best practice guidance. People with specific health issues had care plans not always in line with current standards.
- People's needs were meant to be assessed each month by their key workers to ensure their care plans reflected them. This was not consistently being completed. For example, one person's health had recently declined. Their care plan did not always reflect their new needs.

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

- People were able to access a dining room where their meals could be prepared for them. Every person had food preparation areas in their flat should they wish to be independent.
- Some people had food brought to them from the kitchen as their choice was to remain in their flat. One person receiving this thought the service and food was "Very good".

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

- People had access to a health professional when their health declined. During the inspection two people had ambulances called because staff had identified issues with their health. However, when people had specialist health needs timely contact had not always been made by staff or management.
- Other people told us they could liaise with their GP or nurses when they were feeling unwell. Staff would support them if they were not managing it.
- When district nurses had put specialist equipment in place staff demonstrated they had some knowledge about the instructions to follow.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People were treated with respect and their diversity was valued by staff. One person said, "It is a privilege to live in Chantry Court" and they continued to say, "The carers are very good." Another person said, "Of course they are" when asked if staff were nice. Other people told us, "The care is second to none" and, "They are very caring."
- The management led by example. Both the head of care and registered manager were regularly providing hands on support and modelling caring interactions. People said, "[Registered manager] comes around."
- Compliments we were told as we met with people clearly indicated how well cared for they felt. All interactions between people and staff were positive. Some people were sitting in a communal lounge and a member of kitchen staff passing came and sat with them and joked.

Supporting people to express their views and be involved in making decisions about their care

- People were supported in a range of ways to help promote them making choices. One person said, "They [staff] always do as I ask". One member of staff told us they, "Talk through the options and involve them."
- People were free to move around the village and staff would support them with their preferences.
- Throughout the inspection we saw staff offering people choice when supporting them in their flats. This included what order they wanted things completed in and how they wanted things left prior to leaving them.

Respecting and promoting people's privacy, dignity and independence

- Staff understood how to protect people's privacy and dignity. They knocked on people's flat doors before entering and announced who they were. They respected when people wanted to remain in their flat rather than go into the communal areas of the village. For example, they would take meals to them and spend time socialising if they had space.
- Staff were aware of ways to protect people's and dignity when supporting them with intimate care. They gave examples of how they kept people covered as much as possible.
- Independence was always promoted by the staff. They encouraged people to do as much for themselves and adapted the support around this. One person was able to complete part of certain tasks, so they felt a level of independence. Another person showed us a book they had been writing.

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not identified or updated in their care plans.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's care plans were beginning to be personalised to their individual needs and wishes. When it was possible people and their relatives were involved in discussions about their care plan. However, detailed guidance was not always provided for staff to follow. Neither had some key information been included for some people.
- Staff were aware of changes to people's needs and some monthly reviews had occurred. However, care plans did not always get updated in line with these reviews. For example, people had a change in their ability to make decisions due to declining health. This was not always reflected in their care plans.
- Plans were in place by the management to replace care plans with a new electronic system. They hoped this would help staff keep care plans up to date with people's changing needs.

End of life care and support

- People were being supported in a caring way to meet their end of life wishes by staff. One person currently on end of life care had a detailed care plan with information checked with other health professionals.
- However, staff lacked formal training and limited support was in place to help staff manage these times in a person's life. They were not aware of all the current best practice around supporting people with mouth care. There was a risk staff would not recognise key changes when someone was at end of life.

Improving care quality in response to complaints or concerns

- People knew how to complain and most felt their concerns were listened to. One person told us about an issue they had and said it was resolved by the registered manager. Another person said, "If I am worried I speak with [registered manager]."
- Recent concerns had records of action being taken by the registered manager. However, systems were not being followed to ensure records were accurately being taken. The quality assurance member of staff was working to improve these systems.

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.

- Although people in this service were not publicly funded living at the village, information was shared with people in a variety of ways to meet their needs and differences. People were involved in expressing their

communication preferences. Some chose to have large print whilst others wanted information read out to them.

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

- Activities and a reduction in social isolation was a primary aim for the ethos of the retirement village. This was clearly being demonstrated even though it was not part of this type of inspection.

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The service was not being managed well which led to confusion and there was a lack of quality assurance to ensure people were receiving safe and quality care.
- Multiple breaches of regulation were found during the inspection.
- The management were failing to follow the provider's policies to undertake several tasks in the service including recruitment, quality assurance and training. For example, the recruitment policies and procedures stated everyone should have two references and a criminal record check prior to starting work. Recruitment records did not always show this.
- Management systems were not in place to ensure medicines were safely administered and managed. Staff were not having their competency checked annually in line with the provider's policy. No arrangements were in place to audit the medicine and stock each person had.
- There were a lack of quality assurance systems going back to 2018 to demonstrate the management were monitoring the care and support people were receiving. Multiple errors were found in areas such as care plans, end of life care and medicine management. The provider had been lacking oversight of the service. This meant concerns raised during the inspection had not been identified or resolved or actions taken to mitigate risks found to people.
- Confusion existed about the current management structure at the service. Throughout the inspection the head of care was liaising with the inspector rather than the registered manager. The head of care was relaying information between the registered manager and the inspector. Staff were struggling to identify who was in charge on a daily basis when speaking with us. New trials of a care plan had been carried out by the registered manager involving one of the care staff and not the head of care. Despite the head of care being the person who was meant to be overseeing new ideas.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate the service was effectively managed and people were being kept safe. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- During the inspection the head of care confirmed they will be registering to be the new registered manager and the registered manager will run the retirement village.
- The provider had recently appointed a quality assurance member of staff. Their role would be to drive

improvement in the service. Following the inspection, they produced an action plan with a plan to rectify all the concerns found.

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

- People spoke highly about the management. People said, "[Head of care] is a very clever lady" and "[Head of care] is excellent". Others told us the positive interactions they had with the registered manager when they needed help with things. One person said, "[Registered manager] is very good."
- Like people, staff praised the management of the service. Staff explained they could approach members of management, felt supported and listened to.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The management were aware of their responsibilities to be open and transparent when things went wrong.

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

- Regular village meetings were held for all the residents to attend and discuss what was going well and what could be improved. One person told us they felt most things were listened to. Whilst another felt more management attendance at these meetings would help improve concerns quicker.
- Staff felt supported and listened to most of the time by the management. One member of staff raised concerns that some staff appeared to have more influence than others.
- No recent staff meetings had been held to formally feedback changes or provide staff with opportunities to share their ideas. The management and staff had informed us more informal occasions occurred when staff worked with the members of management.

Working in partnership with others

- The management had developed links with other health and social care professionals. There were further plans to increase positive relationships with more specialist health care professionals.

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
Personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider was not ensuring people received safe care and treatment from suitably qualified staff. Risks were not always being identified or assessed and medicine was not managed safely.</p>
Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Systems were either not in place or robust enough to demonstrate the service was effectively managed and people were being kept safe</p>
Regulated activity	Regulation
Personal care	<p>Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed</p> <p>The provider was not ensuring their systems or legislation was being followed to recruit suitable staff to work with vulnerable people.</p>
Regulated activity	Regulation
Personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>The provider was not ensuring people received safe care and treatment from suitably qualified staff. Risks were not always being identified or assessed and medicine was not managed safely.</p>

