Chestnut View Care Home Limited

Chestnut View

Inspection report

169 Derby Road
Chellaston
Derby
Derbyshire
DE73 5SB

Tel: 01332704511

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06 May 2021

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Chestnut View is a residential care home that can accommodate up to 18 people. At the time of the inspection there were 17 people living in the home. The home is made up of two floors and can support older people and those living with dementia.

People's experience of using this service and what we found
Systems did not always safeguard people from abuse. People were not always protected from avoidable harm and lessons were not always learnt when things went wrong. Medicines were not always managed in line with good practice. Staff training was not up to date and no assessments of competence were undertaken by the registered manager. Procedures were not always in place to ensure risks from infection were reduced.

Policies and procedures were in place to help ensure the quality and safety of services however, these had not always been effective. Audits had not always identified shortfalls and led to improvements in the quality and safety being provided by the service. Records were not always accurate and up to date. Opportunities for continuous learning and improvement had been missed. Working in partnership with others had not always been effective.

Staff had regular supervisions, however staffs' knowledge and understanding on training and people's healthcare needs was not regularly checked on. Some staff lacked knowledge in areas of people's healthcare needs and had poor understanding of completed training such as MCA and DoLS. Referrals to other healthcare services were made but not always reviewed when needed. Peoples care needs were regularly assessed and reviewed but the reviews were not always accurate.

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.

Care plans were not always reflection of people's current needs and it was not clear how people were involved in reviewing these. People's independence was promoted, and people felt respected by staff. People liked the staff team and felt they were kind and caring.

The building was suitable for people living at the service, however there was no accurate risk assessments for people using the steep stair case in leading to first floor . People had varied mealtime experiences. People's weights were monitored for any weight loss.

The provider understood and demonstrated a duty of candour in their approach to complaints management. Checks on equipment and premises were in place however they have not always identified the shortfalls we found on inspection. The management team had acknowledged staff morale and were focussing on achieving good outcomes for people.

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 14 February 2019)

Why we inspected
The inspection was prompted in part due to concerns received about cleanness of the service, medication management, mealtimes experience, management's knowledge of people's needs, not following up referrals to health professionals. A decision was made for us to inspect and examine those risks.

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 COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Following our inspection, the provider began to implement a range of actions designed to mitigate the risks found.

The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Chestnut View 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. We will continue to monitor the service and we will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified four breaches in relation to need for consent, safe care and treatment, safeguarding service users from abuse and improper treatment and good governance at this inspection.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

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 effective?

Requires Improvement

The service was not always effective.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our safe findings below.

Chestnut View

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.

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 team consisted of one inspector and one inspection manager onsite and an assistant inspector offsite who made phone calls to staff and relatives.

Service and service type
Chestnut View 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 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from partner agencies and professionals including the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider was not asked to complete a provider information return prior

to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spent time observing care and support in the communal areas. We observed how staff interacted with people who used the service. We spoke with two people who used the service and two relatives of people who use the service. We spoke with nine members of staff including the manager, deputy manager, senior care workers, care workers, cook, activities coordinator. We spoke with the nominated individual offsite. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included the relevant parts of six people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

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 good. At this inspection this key question has now deteriorated to Inadequate. 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.

Systems and processes to safeguard people from the risk of abuse
• People were not always being protected from abuse. Although the registered manager notified us about the incidents, the safeguarding incidents were not analysed for trends and patterns. This placed people at risk of reoccurring harm.
• People were being unlawfully restrained. Three members of staff we spoke to told us that sometimes people's hands were being held down when delivering personal care. This was not documented in the care plans, risk assessments or daily notes.
• The people who were unlawfully restrained were not able to comment on this practise due to the impact of dementia on their ability to communicate. This means people's liberty of movement was restricted.
• Care plans were not in place to guide this practise and ensure people are supported safely. We shared our concerns about the unlawful restrain with the registered manager and they agreed to address it with staff.
• Staff received safeguarding training but had not recognised that unlawful restraint was taking place or that they were acting against peoples best interests.

Systems and processes had not been operated effectively to prevent abuse of service users. This is 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.

• Relatives and the people we spoke to told us they felt safe living at the home.

Assessing risk, safety monitoring and management
• People were not always protected from avoidable harm. For example, people were not protected from environmental risks. We found hazardous substances such as COSHH chemicals and a box of sharps (used needles) stored in a communal area and within people's reach. This posed a risk to people of ingestion or physical injury.
• The staircase leading to the first floor was steep. Whilst people had individual risk assessments for the use of the staircase, some of them were not up to date and had not mitigated the risks effectively. For example, one person who had several falls and seizures was assessed as safe to use the staircase independently.
• Specialist advice was not always acted on and implemented in people's care plans. For example, one person was not served the correct diet and was at risk of choking.
• Accidents and incidents were not always effectively reviewed in order to learn from these and reduce recurrence.

Lessons when things go wrong.

• Lessons were not always learnt from incidents that occurred. For example, a number of altercations between people were recorded and reported, however the provider did not consider trends and patterns to reduce the risk of reoccurring.

Using medicines safely
• Medicines in stock did not always equate with the quantities recorded as available. The provider was therefore unable to provide assurances people had received their medicine as prescribed.
• Protocols for medicines that were taken "as needed" (PRN) did not contain enough information to support staff to administer it correctly, however senior care staff were aware when people required PRN medication.

• The provider completed medication audits, but these were not always effective in identifying the shortfalls we found during our visit such as issues with the stock count. This means the people were put at risk of not having their medication when needed.

Risks had not been managed safely. This is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
• There was increased risk of spreading of infection. This puts people and staff at increased risk of transmitting infections, including COVID-19
• We were not assured that the provider was meeting shielding and social distancing rules.
• We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises.
• We were not assured that the provider was using PPE effectively and safely.
We have also signposted the provider to resources to develop their approach.

Risks relating to infection control had not been managed safely. This is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
• We were assured that the provider was admitting people safely to the service.
• We were assured that the provider was accessing testing for people using the service and staff.
• We were assured that the provider's infection prevention and control policy was up to date.
• We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Staffing and recruitment
• There was no effective competence checks to check care staff's understanding of the training. For example, staff did not recognise unlawful restraint or the importance of providing people with the prescribed diet.
• We received varied feedback about staffing levels. People told us they did not usually have to wait for support when required. However, staff told us the number of staff was not always sufficient to respond to frequent altercations between people and meet the needs of people who presented with behaviour that challenges.
• The register manager told us they reviewed and adjusted staffing levels as people's needs changed.
• When staff were recruited the appropriate references and checks were completed in line with current guidance.

Requires Improvement

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.

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
• For people who lacked mental capacity and required ongoing supervision, timely referrals had not been made for Deprivation of Liberty Safeguards. The safeguards aim to make sure that service users in care are looked after in a way that does not inappropriately restrict their freedom. Of the three DoLS authorisations we requested the registered manager could not find one form and the other two DoLS authorisations had expired. This puts people at risk of being deprived of their liberty unlawfully.

The failure to ensure that people were not being deprived of their liberty was a breach of Regulation 13 Safeguarding service users from abuse and improper treatment.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Where people were not able to make a decision for themselves, mental capacity assessments had not always been completed. For example, one incident record stated a person's mobile phone was confiscated. The registered manager was unable to tell us the reasoning behind this as no MCA or best interest decision discussion had taken place. This decision had not been assessed in line with the Mental Capacity Act 2005 and this was the least restrictive option in the best interests of the person.
• Two people lived in a shared bedroom and had not consented to this arrangement. The registered manager was unable to provide us with any mental capacity assessment or best interest decision into the sharing the bedroom. There was no privacy curtain or screen available in the bedroom. The care staff provided us with conflicting information regarding how the people's privacy was maintained during personal care. We could not be assured that the decision made for the two people to share a bedroom was in their best interest.

• Staff had recently attended training on DoLS and MCA in March 2021. However, their knowledge and understanding was poor. The staff lacking knowledge about mental capacity increased the risk of service users' rights under the Mental Capacity Act 2005 not being protected.
• People's care plans were not always detailed and did not always reflect people's needs. For example, we looked at care plans of two people with behaviour that challenges and the guidance for the care staff to meet those needs was not detailed enough to give guidance on how to de-escalate the behaviour.

People's care was not always delivered in line with standards, guidance and the law. The provider failed to ensure they gained the appropriate consent from the relevant person and in line with the MCA 2005. This is a breach of Regulation 11: Need for consent, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff support: induction, training, skills and experience
• Staff had not received training in all areas of people's healthcare needs, for example first aid, nutrition and dementia training. The provider told us they will be taking steps to source the training following our inspection.
• Supervisions were not always effective. Supervision provides staff members with the opportunity to reflect and learn from their practice, embed knowledge, check competence and receive personal support and professional development. Staff had frequent supervisions; however, the supervisions did not always identify the gaps in staff's knowledge.

Supporting people to eat and drink enough to maintain a balanced diet
• We observed a varied dining experience. Some people who required helped with their meals were supported in a caring and dignified way. However, other people who needed support were not attended to despite staff being available in the dining area. For example, one person who kept falling asleep by the dining table was not given enough, timely support to enjoy the meal. The person was not attended to for 20 minutes after the meal served. One person was assisted with the meal by a carer who was standing up by the person, instead of sitting down with the person to provide dignifying support.
• People were not always supported with the correct diet. Staff were not always sure about people's dietary needs and we observed one person being served incorrect type of food for their needs which posed a risk of choking. Following the inspection we have made a safeguarding referral to ensure the person was safe and we advised the provider to contact Speech and Language Therapist (SALT) to reassess this person's dietary needs.
• At lunch time, we observed people taking food off each other's plates and sharing cutleries. This occurred despite staff being present in the dining room and observing the situation. This has increased the risk of infection of spreading and impacted on some people's dining experience.
• We observed some people were provided with plate guards to promote independent eating.
• People told us the they enjoyed food at Chestnut View. One person told us, "It is quite flexible, you can choose what you want, and the food is usually nice".
• People's weights were monitored for any weight loss and actions were taken where there were concerned about people's weight loss. For example, timely referrals to GP.

Staff working with other agencies to provide consistent, effective, timely care
• The provider did not always communicate with other professionals in a timely way to reduce new risks. For example, when one person did not like the diet recommended by Speech and Language Therapist, the provider did not contact them again to review and consider an alternative diet.
• Records showed other healthcare professionals such as GP's and occupational therapists were involved in people's care as required.
• Emergency health care was sought in a timely way when required.

Adapting service, design, decoration to meet people's needs

• There were some signs to aid people to help them to orientate themselves but the information on the prompts were not always correct. For example, the board in the hallway had incorrect day and date written on it. This could contribute to confusion for people living with dementia.

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 Good. At this inspection this key question has now 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• Oversight and management of risks had not always been well managed, and people had not been effectively protected from known risks. The quality assurance processes such as audits were not always effective.
• Environmental risk assessments were not effective and not identified risks. For example, cleaning products and sharps (used needles) being left in the communal areas.
• Medicines audits had not always been effective at identifying all issues we identified or in bringing about improvements. For example, guidance on administration of PRN medication and stock checks.
• The care plan audits did not identify shortfalls around care plans. Care plans were not always up to date or accurate. We found care plans contained contradictory and inaccurate information on people's care needs.
• The infection control audits hadn't identified issues around use and disposal of Personal Protective Equipment (PPE) was not in accordance with the government's guidance. PPE helps protect staff from being contaminated with coronavirus when delivering care and spreading infection. The donning and doffing stations were not consistently well equipped which can lead to more opportunities for cross-contamination.

Continuous learning and improving care; Working in partnership with others; 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 provider had failed to identify and address trends of safeguarding incidents and consequently had missed opportunities to improve the safety of the service.
• Incidents of behaviours that challenged had not been analysed to help inform continuous learning and improve care and safety.
• Working in partnership with others had not always been effective as other professionals' guidance was not always followed.

Systems and processes designed to assess, monitor and improve the quality and safety of services and reduce risks had not been operated effectively. This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider demonstrated their duty of candour when managing any complaints to the service.
• The provider did not display their rating. Providers must display CQC ratings on posters at premises and on websites no later than 21 calendar days after we have published them on our website. This is a requirement

of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20A.
• We received statutory notifications from the provider as per the legal requirement.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Staff had mixed views on working at the service. The registered manager offered staff the opportunity to discuss any issues during supervisions and team meetings, however not all staff felt their views, and concerns had been acted on.
• People told us they felt involved in the service. One person told us, "We have no meetings, but we have discussions with staff. I would be comfortable to share ideas with anyone, any of the nurses, there is no problem with that".
• Policies and procedures were in place to ensure people's equality characteristics were considered.

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 11 HSCA RA Regulations 2014 Need for consent People's care was not always delivered in line with standards, guidance and the law.

The enforcement action we took:

Registered Provider must conduct audits and carry out a review of the systems in place and feedback to CQC. The Registered Provider must not admit any new service users to Chestnut View 169 Derby Rd, Chellaston, Derby, DE73 5SB without the prior written agreement of the Care Quality Commission.

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

The enforcement action we took:

Registered Provider must conduct audits and carry out a review of the systems in place and feedback to CQC. The Registered Provider must not admit any new service users to Chestnut View 169 Derby Rd, Chellaston, Derby, DE73 5SB without the prior written agreement of the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Some people were deprived of their liberty for the purpose of receiving care or treatment without lawful authority. Some people's liberty of movement was restricted during personal care.

The enforcement action we took:

Registered Provider must conduct audits and carry out a review of the systems in place and feedback to CQC. The Registered Provider must not admit any new service users to Chestnut View 169 Derby Rd, Chellaston, Derby, DE73 5SB without the prior written agreement of the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People's care and treatment were not always provided in a safe way.

The enforcement action we took:

Registered Provider must conduct audits and carry out a review of the systems in place and feedback to CQC. The Registered Provider must not admit any new service users to Chestnut
View 169 Derby Rd, Chellaston, Derby, DE73 5SB without the prior written agreement of the Care Quality Commission.