Chantry Retirement Homes Limited

Euroclydon Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Euroclydon Nursing Home is a residential care home providing accommodation to persons who require nursing or personal care, to up to 48 people. The service provides support to older people; some whom live with dementia. At the time of our inspection there were 32 people using the service. People are accommodated in one adapted building split over two floors.

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

People were placed at risk of not receiving their medicines as prescribed. Staff had not always ensured people had access to their prescribed medicines.

Infection prevention and control was not always effective. Staff were not always wearing PPE in line with government guidance. This placed, people, visitors and staff at risks of infection. The manager had taken immediate action during our inspection to address these concerns.

People were not always protected from the risks of their environment. The provider had not undertaken effective measures to ensure that service users would be protected from risks associated with fire safety.

There were limited monitoring systems in place, and systems operated by the service had not identified or addressed concerns found during our inspection. This included concerns in relation to infection control, medicine management, fire safety and people's person-centred care.

A new manager was in place, who staff and relatives spoke positively about. The manager had made some positive changes to the service, however the provider had limited oversight to ensure the service was meeting the required regulations.

During the inspection the manager took immediate action in relation to PPE. Following the inspection, the manager provided the inspection team with a service improvement plan. They told us they were committed to improving the service.

The service had not always sent required notifications to the Care Quality Commission (CQC) without delay.

People's care plans detailed their individual risk and the support they required. Staff understood people's needs and how to protect them from the risks associated with their care.

The manager had increased staffing levels prior to our inspection. Staff and people told us there were enough staff to meet their needs. The manager was ensuring all staff had access to training to meet people's needs.

People told us they felt safe and well looked after. They told us the staff were tolerant, patient and friendly.

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 29 July 2021).

Why we inspected
This inspection was prompted by a review of the information we held about this service. This included information about the people's assessed care needs, associated risks and falls management.

As a result, we undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Euroclydon Nursing Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
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 will take further action if needed.

We have identified breaches in relation to safe care and treatment, good governance and reporting incidents 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, which will help inform when we next inspect.

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 always safe.

Details are in our safe findings below

Is the service well-led?

Requires Improvement

The service was not well-led.

Details are in our well-led findings below

Euroclydon 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. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

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
Two inspectors and an Expert by Experience carried out this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Euroclydon Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Euroclydon Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. At the time of our inspection there wasn't a registered manager in post. A manager had recently started working at Euroclydon Nursing Home and was planning to register with CQC.

Notice of inspection
This inspection was unannounced. We inspected the care home on 6 July and 7 July 2022.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with nine people who used the service to learn about their experiences of the service provided to them. 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 also spoke with six people's relatives. We spoke with six members of staff. This included two care staff, one housekeeping staff, activity co-ordinator, the chef and a nurse. We spoke with the manager and a representative of the provider.

We inspected the care records of four people. We inspected two staff recruitment files and a selection of medicine and maintenance records. We reviewed records pertaining to the management and quality monitoring of the service. We requested and received copies of the homes the service improvement plan.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question remains the same. 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

● People did not always receive their medicines as prescribed. There were more medicines in stock for four people that we would have expected to find if they all received all their doses as prescribed. These medicine omissions had not always been identified by staff as they had not accurately checked people's medicine stocks against recorded administrations on people's medicine administration records.

● One person was prescribed medicines that where to be administered 'as required' when they could be anxious or distressed. Staff had administered this person this medicine daily for 24 days and had not followed their 'as required' protocol. This could place the persons health and wellbeing at risk. We discussed this with the manager who arranged for a GP to review the person's medicines to ensure they were effective.

People had not received their medicines as prescribed. Staff did not follow recognised good practice when managing people's prescribed medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's medicines were stored securely, and within appropriate conditions as per manufacturer guidelines. Where people received support with prescribed controlled medicines, these were managed safely and securely.

Assessing risk, safety monitoring and management

● People were not always protected from the risks of their environment as the risks associated with fire had not been sufficiently addressed. Local fire and rescue services had raised concerns in relation to fire safety practices in April 2022. The provider had arranged for a fire risk assessment to be carried out, however a number of remedial actions that posed a risk to people remained outstanding. We requested and received a response from the provider on the actions they were planning to take and how they were planning to mitigate the fire related risks to people living at Euroclydon Nursing Home.

● Not everyone living at Euroclydon Nursing Home had a Personalised Emergency Evacuation Plan (PEEP). Where PEEPs were in place, they were not always current and reflective of people's needs, which meant staff would not have clear guidance to follow to assist people to evacuate or stay safe in the event of a fire. The manager informed us they had taken immediate action to address this after our inspection.

● Water temperatures were being monitored and recorded on a monthly basis. Some temperatures recorded were outside of the providers expected limits to prevent scalding and the risk of bacterial growth. The service had reported boiler issues. Shortly after our inspection, the provider confirmed a new boiler had been installed within the home to prevent further concerns.

People had not always been protected from the risks associated with their environment. People could always be assured of their safety in the event of a fire. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Risks to people in relation to other aspects of their care were assessed and managed safely. Risk assessments clearly guided staff to care for people in a safe way. We saw assessments for the risk of falling, eating and drinking and skin care. They detailed measures to manage the risks and were reviewed regularly or as soon as people's needs changed.
● Staff were proactive at identifying any new areas of risk, assessing these and taking action to mitigate these risks. One agency nurse told us "It is good here. I know what support people need, which dressing. It is easy. Staff they do raise things and help me."

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. However, at the time of our inspection, the manager did not have a clear record of where applications were pending with legal authorities. Following the inspection, the manager had engaged with legal authorities to chase pending applications. Additionally, we identified the provider had not always informed us of when DoLS notifications had been approved, which is a legal requirement as part of their registration.

Preventing and controlling infection
● We were somewhat assured that the provider was using PPE effectively and safely. On the first day of our inspection, staff were not wearing face masks. The service was not following government COVID-19 guidance. The manager took immediate action to address this concern. On the second day all staff were wearing PPE in accordance with government guidance.

People had not always been protected from the spread of infection. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were somewhat 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 accessing testing for people using the service and staff.
● We were somewhat 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.

Following the inspection, we signposted Euroclydon Nursing Home to local authority support in relation to infection control and prevention.

Visiting in care homes
The provider was following current government guidance in relation to visiting at the time of the inspection.

Systems and processes to safeguard people from the risk of abuse
● People and their relatives told us they felt the home was safe. One person told us, "I feel safe, no issues." One relative told us, "I think she is safe; she says she feels safe there and they know her."
● The manager and representatives of the provider were visible and regularly worked alongside staff and met people's visitors. One member of staff told us, "I feel it's safe. The standard of care is good here."
● Staff had read the provider's whistleblowing policy and procedures and felt able to report any concerns about poor practice or inappropriate staff behaviour.
● We found one incident that required notification to CQC but this had not been submitted. We found that the manager had taken appropriate action to investigate and keep this person, however in the absence of a notification we had not been informed of the actions the manager had taken in accordance with the regulations.

Learning lessons when things go wrong
● During the inspection the manager and representatives of the provider took immediate action in relation to our concerns around fire safety and medicine management.

Staffing and recruitment
● Suitable staffing levels were in place to meet the needs of people using the service. In response to recruitment concerns the provider had employed staff as part of a sponsorship scheme. This scheme was co-ordinated with the government.
● Since coming into post, the manager had increased care staff numbers within the home as a matter of priority. People, their relatives and staff discussed this positively.
● Staff told us there were enough staff and they had the time they needed to provided people's care.
● Staff were recruited safely. All required checks were made before new staff began working at the home. Disclosure and Barring Service (DBS) checks were completed alongside seeking references from staff's previous employers. These checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Requires Improvement

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 our last inspection we rated this key question Good. At this inspection the rating has changed 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.

- The home had a manager who had only recently started working at Euroclydon Nursing Home. The manager had experience in relation to community-based care and was new to residential based care. The manager had not received a hand over from the previous registered manager and had therefore not been made aware of any known quality or risk issues that needed to be addressed. Since the manager had been in place they had prioritised staffing numbers and cleaning practices in the home.
- There were not always audits and management systems in place to monitor the quality and risks in the home. The manager was aware of this and had started to monitor infection control, call bells and management of medicines. The manager understood the Deprivation of Liberty safeguards (DoLS) processes, but did not have a system in place to see when applications had been made to deprive someone of their liberty so that these could be notified to CQC and people's care plans updated promptly.
- The provider confirmed that they had not carried out audits or checks at Euroclydon Nursing Home to ensure themselves the service was meeting the regulations. They had therefore not identified and addressed concerns we found at this inspection in relation to correct PPE usage, fire safety and medicine management. They had not robustly checked that staff were working in accordance with their policies and that the service have appropriate support through a management change.
- The provider operated an electronic care planning system. This system enabled them to generate reports in relation to incident and accidents and people's personal care. At this time this system was not being fully used to identify any concerns. For example, we identified two people had been placed at risk of not always receiving personal care, however the provider had not identified this shortfall.

Continuous learning and improving care; Working in partnership with others, Engaging and involving people using the service, the public and staff, fully considering their equality; 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 did not have systems in place to seek the views of people and their relatives. There was no current record of survey or engagement with relatives to ensure feedback could be provided and used to improve the service.
- The provider had no current service improvement plan for Euroclydon Nursing Home, which considered actions from the fire risk assessment and any other actions they may be aware of. This meant no record was available for the provider and manager to refer to when monitoring whether improvements were being made and if people were protected from the impact of any identified shortfalls. Following the inspection the

manager created a service improvement plan which included information on our concerns.

All the above demonstrated that the provider did not always operate effective systems to assess, monitor and improve the quality of care people received. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had failed to send some required notifications to the Care Quality Commission without delay. This impacted on the ability of the CQC to effectively monitor the safety of people as information was not available at the time of these events. CQC monitors important events affecting the welfare, health and safety of people living in the home through the notifications sent to us by providers. They had failed to identify this shortfall through their own monitoring systems.

The provider did not always notify the Commission without delay of the incidents which occurred as a consequence of the carrying on of the personal care to people. This was a breach of Regulation 18 (1) of the Care Quality Commission (Registration) Regulations 2009

● People, their relatives and staff spoke highly of the manager. Comments included: "I would go to the manager, we get on great, I would be happy to talk to her"; "If I'm not happy I would take to [manager], they are very new and we are getting to know them, they are very approachable" and "And issues I would speak with [administrator] or [manager]." The manager had taken some actions around staffing prior to our inspection.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Management were visible in the service and approachable.
● Staff told us they felt able to raise concerns with the manager without fear of what might happen as a result.
● The manager was arranging training for staff to help them identify the support and skills the staffing team required. They had organised moving and handling training for all staff as they had identified this as an area of development.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person did not always notify the Commission without delay of the incidents which occurred whilst services were being provided, or as a consequence of the carrying on of the regulated activity service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured environmental risks had been appropriately managed. People did not always receive their medicines as prescribed. People had not always been protected from the risk of infection.

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered person had failed to apply effective governance to ensure quality of care for people was appropriate.

The enforcement action we took:

We issued the provider with a warning notice in relation to regulation 17 at Euroclydon Nursing Home.