Chilterns Healthcare Limited

Chilterns Manor

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Chilterns Manor is a residential care home providing accommodation and personal care for up to 22 people. The service provides support to older people and people with dementia. At the time of our inspection there were 18 people using the service. Chilterns Manor provides accommodation in one adapted building.

People's experience of using this service and what we found
People did not receive safe care. We found staff did not consistently follow good hygiene practices at the home, to prevent the spread of infection. There had not been any training on infection control or correct use of personal protective equipment (PPE).

The home did not have robust recruitment procedures. Some of the personnel files did not contain evidence of all required checks. One member of staff was unable to understand English, some others had poor interactions with people. We could not see how they could have demonstrated they had the skills and experience for the roles they were appointed to.

A visiting professional told us some people said staff did not treat them with dignity and respect. People said they did not always feel listened to and staff did not talk to them much. We observed this during the first day of our inspection.

People lived in a building which had not always been maintained to a safe and comfortable standard. For example, a fire exit door was obstructed in the dining room and the route it led out to was unsafe and enclosed by construction fencing. We reported our concerns to the fire service, who visited the home and required action to be taken.

The premises looked uncared for. We found bags of rubbish in the garden and cigarette ends by the front door and in the garden. Some of the furniture was worn and needed replacing.

Regulatory requirements were not being met. For example, the provider had not notified us of events they were required to, such as an unexplained head injury and missing antipsychotic medicine. We found medicine prescribed to be given by injection had been administered by two of the staff team, who were nurses. However, this was not permitted under the home's registration status. We asked the provider to stop this with immediate effect. Accidents and incidents had not always been recorded. Injuries and safeguarding concerns had not consistently been reported to the local authority.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. Applications were made to the local authority where people were deprived of their liberty. We have made a recommendation regarding checking who has lasting power of attorney.

The provider was not proactive in seeking and responding to feedback to improve people's care. Monitoring

and auditing processes were ineffective. Care practice was either not being monitored or poor practice was not always recognised. For example, we observed a mealtime where pop music was being played on the television and people had not been supported to maintain appropriate posture to manage their meal comfortably. We have made a recommendation to improve mealtimes.

Care records were not always written in a person-centred way to ensure individual needs and preferences were taken into account and met by staff. Records were not always accurate or in sufficient detail to document people's care. There was a lack of understanding about the requirement to be open and transparent under duty of candour.

The quality of people's care had deteriorated significantly from the previous inspection. Feedback about the home from relatives was negative. People had concerns about the quality of care. In a couple of cases, families told us they were considering moving their relative to another care home.

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 (report published 17 October 2018).

Why we inspected
We received concerns in relation to an injury a person sustained. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led only.

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.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led sections of this report.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Chilterns Manor 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 safeguarding people from abuse, safe care and treatment, recruitment practice, being open and transparent (duty of candour) and governance of the service. The

provider additionally failed to notify us of significant events.

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 from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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 well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Chilterns Manor

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
The inspection was carried out by one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. They contacted a sample of relatives or people's representatives by telephone.

Service and service type
Chilterns Manor 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. Chilterns Manor is a care home without 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 was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received and held about the service. We sought feedback from the local authority and professionals who work with the service. We contacted staff by email, to invite them to provide feedback.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We took into account information provided in the previous PIR from September 2021.

We used all this information to plan our inspection.

During the inspection
We spoke with three people who used the service. We had discussions with the manager, chef, a range of housekeeping and care staff. We had discussions with eight relatives by telephone. We looked at a sample of records. These included five care plans and associated documents such as risk assessments and daily notes, four staff recruitment files, checks carried out for four agency workers, the staff training matrix and staffing rotas. We checked a sample of quality assurance audits and records related to maintenance and upkeep of the premises. We viewed a range of health and safety records including accident and incident reports.

After the inspection
We requested additional evidence from the manager.

We informed the fire authority of our concerns about fire safety at the home. A visit was subsequently carried out by a fire safety officer on 24 August 2022.

Inadequate

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 good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse
• People were not safeguarded from the risk of abuse.
• Staff were unaware of the need for unexplained bruising to be investigated. We found instances on handover records and care notes where bruising was noted. We asked what action was taken in these instances and were told it was noted on the computer system. The manager said no other action was taken. There was no process to refer to the safeguarding team.
• From other records, we found injuries had been sustained from physical altercations between people. These also had not been referred to the local authority.
• A family member told us "My relative had some bruising from an altercation with another resident, they don't do body mapping and this was not noted."
• Daily notes stated an ambulance had been called in March this year as one person "was found with a head injury." There was no further information about this at the home, no accident or incident form was completed and no safeguarding referral was made. The manager was unable to provide any details of what had happened or the extent of the injury.
• A member of staff had carried out an inappropriate procedure on another person, resulting in hospital admission. This was the subject of an on-going safeguarding and police investigation.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to protect people from the risk of abuse and improper treatment. Effective systems and processes had not been established and were not operated to investigate allegations of abuse.

Preventing and controlling infection
• We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. For example, we found items stored in bathrooms which prevented effective cleaning and could spread infection. We also observed a member of housekeeping staff remove individual items from a waste bin by hand and place them in a carrier bag for disposal, rather than remove the bin liner and contents together. At lunchtime, we observed a lid from the heated food trolley being placed on the carpet in the lounge, until a suitable place could be found for it. This risked spreading infection.
• We were not assured that the provider was using PPE effectively and safely. We observed some staff did not consistently have their nose and mouth covered by a face mask. One removed their mask when speaking. We came across a used face mask and gloves which had not been disposed of safely, lying on top of bags of rubbish in the garden.
• We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed. None of the staff had been provided with infection control training or correct use of PPE. A

member of housekeeping staff was unable to understand and answer questions about managing infection risks and spread of infection.
• From our overall observations of practice, we were not assured that the provider would be able to respond effectively to risks and signs of infection. Although there was an undated infection prevention and control policy in place, there was poor implementation of this.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to adequately assess, prevent, detect and control the spread of infection.

• We were assured that the provider was preventing visitors from catching and spreading infections.
• There had not been any admissions to the home. The manager was able to provide assurance that people would be admitted safely to the service.

Visiting in care homes
We saw visitors were able to visit their relatives at the home. This aligned with government guidance at the time.

Using medicines safely
• People's medicines were not always managed properly or safely.
• We came across records which showed antipsychotic medicine had gone missing from the home in July this year. We had not been informed of this and it had not been reported to the police.
• The care plan for the person who required the antipsychotic medicine stated it was to be given by intramuscular injection, either by the mental health team or the home manager. We queried this with the manager, who confirmed they and another senior member of staff had given the injection on four occasions. Although both are qualified nurses, this is not permissible under the service's care home registration. The provider was instructed to cease this practice with immediate effect.
• There were no records to show either permanent or agency staff had been assessed at the home, to check their competency to handle and administer medicines.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to ensure people's medicines were managed properly and safely.

• After the first day of the inspection, the manager told us a start had been made on assessing one agency worker's medicines competency.

Assessing risk, safety monitoring and management
• People were not kept safe and the likelihood of injury or harm had not been reduced.
• Fire safety measures were not sufficient to protect people from the risk of fire.
• Staff were not alert to fire safety risks. We found a bedroom door propped open with a portable heater. We mentioned this to the manager on the first day. It was still being propped open on the second day of the inspection, until the maintenance person was able to repair it. Staff had not considered the need to remove the heater and keep the door closed.
• We found a fire exit route was obstructed by a table and chairs in the dining room. The door had a large sign on it saying 'fire exit, keep clear.' The escape route beyond this door was further impeded by the condition of the garden, which contained trip hazards and was enclosed by tall metal construction fencing. This would have prevented safe and timely evacuation.
• Records showed the last fire drill was carried out in January this year. Since then the home had a new staff team. No fire drills had been carried out for them to rehearse what to do in the event of a fire. This placed them and the people they supported at risk of harm.

• The premises had not been well-maintained. The grounds were in poor condition, to the extent that people could not safely use the garden. Furniture provided in people's rooms was worn and needed replacing.
• Relatives were critical of the condition of the home. Comments included "They've started building so now she has no access to outside space," "My first impressions were horrendous, the room was not fit for purpose" and "Cleaning could improve and it's generally a bit shabby."

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to assess the risks to the health and safety of service users and done all that is reasonably practicable to mitigate any such risks.

• We referred the fire safety concerns to the fire safety officer, who visited the premises and required action to be taken.
• Staff had received training on moving and handling. No competency assessments were carried out to make sure learning was put in to practice. We mentioned this to the manager, for action to be taken.
• Records were in place to show equipment was serviced, electrical appliances were tested and the gas installation was safe.
• Risk assessments were in place in people's care plans and had been kept under review.

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.
• Best interest decision records were in place where people lacked capacity to make decisions about their care.
• Applications had been made to the local authority to grant authorisation for deprivation of liberty. Some decisions had been granted, others were waiting for approval.
• We were not provided with evidence the home had obtained verification of who had been granted lasting power of attorney. This is necessary to ensure only authorised people make decisions on people's behalf.

We recommend good practice is followed regarding checking lasting power of attorney.

Staffing and recruitment
• Staff were not always recruited using robust procedures. This meant people may not be supported by workers with the skills and competencies to meet their needs.
• In one recruitment file, there were no references to support the person's application. In two other files, there was only one reference each, with limited information about the skills and experience that were required. Additionally, one of these files did not contain any proof of identification for the worker.
• Application forms had not always been completed fully, to show how the person considered they met the competencies for their role. For example, in one file the section on why the applicant thought they should be considered for the job was left blank. They had no previous experience of working in the care sector.
• One worker had only a basic understanding of English and could not respond to our questions. It was

difficult to see how they could demonstrate at interview they met the criteria for their role.
• We observed staff interactions with people. From the first day of the inspection, we reported to the manager poor or few interactions by some care workers. For example, one person was being assisted by a care worker to come downstairs. The only time the member of staff spoke with them was to say "Sit" when they got to the stairlift and "Wait, wait" when they reached the bottom.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to ensure people were cared for by workers who had the qualifications, competence, skills and experience necessary for the work performed by them.

• We observed better interactions by the staff team who were present during the second day of the inspection.

Learning lessons when things go wrong
• There was some evidence of improvements being made when things went wrong. However, accident and incident records had not always been completed so it was not always possible to see if preventative measures were put in place, where necessary.

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 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
• We had not received notification about some events the provider was required to tell us about, such as unexplained bruising, incidents between people resulting in injuries, an unexplained head injury and missing antipsychotic medicine. This placed people at risk of further harm and unsafe care.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009, as the provider had not notified us of all events it was required to.

• The home had a new manager in post. They had applied to become registered with the Care Quality Commission.
• Care plans had been written for each person, to outline the support they needed. We read these in conjunction with daily notes about people's health and well-being.
• We found some information was generalised and phrasing was repeated or very similar from care plan to care plan. We could not be confident individual needs and preferences were therefore being met.
• A community professional told us "I have concerns over the quality of recording in the daily notes. Many of the notes are not person-centred, and just state 'was happy' or 'was content'."
• They added "Recording is not always accurate. For example, one client was just given a plate of chips and marked as having the vegetarian option for lunch…same comments are put for many different residents. On one care plan it stated client could be very aggressive but there was no behaviour chart in place and no notes as to what should be done to manage the behaviour."
• Some staff had recorded urine output for people who used incontinence pads. It would not be possible to measure this from a soiled pad therefore the amounts written down were guessed, for example, 750 ml. This would be an unnaturally excessive amount of urine to produce.
• Staff recorded fluid intake in people's daily notes, however quantities were estimations. For example, we saw entries such as "offered 150 ml, drank 145 ml," "offered 150 ml, drank 115 ml", "offered 200ml, drank 190 ml." We asked the manager how staff knew the precise amount consumed. They said these amounts were guessed, not measured.
• A community professional told us the home was not effectively managing monitoring fluid intake. They said "Several residents were on a fluid chart and intake was being monitored but no target was given on the document, so you would not know if they were reaching the ideal amount each day." This showed records were unreliable in outlining people's needs and how these were being met.
• We asked to look at records of monitoring and auditing, covering the previous 12 months. We could see

audits had taken place recently for areas such as catering, the environment and infection control practice. These did not identify the issues we found during the inspection.
• We asked for and read records of monitoring carried out by the provider. We were sent a document with bullet points under headings for each month. In most cases, the monitoring record for each month covered less than half a page and contained a list of tasks. For example, in June 2022 "accepted (name) resignation," "ordered equipment for handyman," "ordered replacement fridge," "reduced agency hours due to recruitment of permanent staff" and "asked (manager) to email me over the latest version of the action plan."
• There was no mention of the provider being aware of incidents and any follow up to these, to ensure people's safety. There were very few indications of engagement with people living at the home and staff, to assess and observe quality of care.
• None of the issues we found during the inspection had been identified by the provider. This showed quality assurance systems were ineffective in identifying risks to people's health, safety and welfare.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had failed to ensure systems or processes were in place to assess, monitor and improve the quality and safety of the service.

• Care practice was not effectively monitored. For example, we observed mealtimes. At lunchtime, we noticed the television was left on, playing pop music from the 1980s. People who remained seated in armchairs were not at comfortable height to manage eating from side tables. This caused them to reach forward each time or twist sideways to eat. Food was also spilled because they were not sitting close enough to their plate.

We recommend the provider adopts good practice guidance in supporting people to manage their meals effectively.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• People told us they did not feel the home engaged and involved them. Comments included "Communication is very poor, they don't tell us anything. There's a change of management, a change of staff, lack of continuity and lots of temps. I'm uneasy about it." "There was a family friendly atmosphere which suited my relative. Initially there was a settled, familiar staff. Since the manager left I am less happy with communication." "They now don't communicate apart from the bill. I had no communication, not feedback following a hospital appointment." "They sent me a link to a portal and said information would be on there about my relative, but there's been nothing. It's pie in the sky."
• We asked relatives if they knew how to make a complaint. Family members said there had not been any proactive attempts to communicate a complaints process.
• We looked at feedback from a provider survey exercise from August this year. Nine surveys had been completed with support from staff. Overall, people said they were happy with their care. However, feedback included some negative comments about staff. For example, one person said they were only sometimes treated with dignity and respect, another commented "We hardly speak" and another said "Some (staff) are very domineering." Another comment was "There are some staff who are very strict." There had not been any follow up to these surveys although the manager did tell us they were aware of two staff whose performance needed to improve.
• Apart from a residents' survey, there was little to demonstrate people were consulted about their care or encouraged to engage in how things were done at the service.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had failed to seek and act on feedback from relevant persons for the purposes of continually evaluating and improving the service.

• Relatives were critical of the care the home provided. Comments included "I have a number of concerns, dirty nails, hair and seems to have very few clothes. I have told the social worker these things. I have not raised issues with the home as we were concerned (person) was in danger." "The service is terrible, the care is terrible." "We have regular contact with social services and there is a safeguarding in place."
• Two of the family members said their impressions had been "horrendous". Some relatives said they were now considering moving their family member because of their concerns about the care.

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
• There are specific things providers need to do to demonstrate duty of candour: telling the person (or, where appropriate, their advocate, carer or family) when something has gone wrong, apologise to the person (or, where appropriate, their advocate, carer or family) and offer an appropriate remedy or support to put matters right, if possible. There was no evidence to show the provider had done this following all relevant incidents.

This was a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had failed to fully demonstrate they acted in an open and transparent way and took appropriate actions to meet the duty of candour requirement.

Continuous learning and improving care; Working in partnership with others
• The findings of our inspection showed the quality of people's care had deteriorated from the previous inspection, as regulations were not being met.
• The manager told us about improvements they intended to make. They said the current focus was on providing training for the staff team.
• We could see staff worked alongside health and social care professionals such as GPs.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified us of all events it was required to. Regulation 18

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 The provider had failed to ensure systems and processes were established and operated effectively to investigate any allegation or evidence of abuse. Regulation 13

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured people were cared for by workers who had the necessary skills and had been recruited using effective processes. Regulation 19

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour

The provider had failed to fully demonstrate they acted in an open and transparent way and took appropriate actions to meet the duty of candour requirement.

Regulation 20

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not taken adequate measures to assess and mitigate the risks to prevent, detect and control the spread of infection; ensure proper and safe management of medicines; ensure the premises are safe to use. Regulation 12

The enforcement action we took:

we issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure systems or processes were in place to assess, monitor and improve the quality and safety of the service. The provider had failed to seek and act on feedback from relevant persons for the purposes of continually evaluating and arriving the service. Regulation 17

The enforcement action we took:

we issued a warning notice