Mr & Mrs P A Whitehouse

# Chaxhill Hall

## Inspection report

Chaxhill
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Gloucestershire
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Tel: 01452760717

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07 January 2021
09 February 2021
11 February 2021

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25 March 2021

## 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
Chaxhill Hall is a residential care home, providing personal care for 21 people aged 65 and over at the time of the inspection. The service can support up to 36 people with a variety of needs, some of whom live with dementia and/or disability. Chaxhill Hall accommodates 36 people in one adapted building.

People's experience of using this service and what we found
People had not always been protected from the risk of spread of infection. The service had implemented recommendations made by an infection prevention and control (IPC) specialist during a Covid-19 outbreak at the service in January 2021. However, we found further improvement was needed to ensure IPC risks were managed safely in line with best practice and national guidance.

People's risks had been assessed and support plans were in place to guide staff in supporting them safely. However, changes to people's weight and accident reports had not always been acted upon in a timely way, to ensure new risks to people were managed promptly.

People may not always have been protected from abuse as the service had not always done all expected of them in response to safeguarding concerns.

People did not always receive their medicines safely.

People had enough staff suitable staff to support them.

People were not protected by robust systems to monitor and improve the quality and safety of the service. Accurate and complete records had not always been maintained.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 22 May 2018).

Why we inspected
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 received concerns in relation to people's safety, people's medicines and the staff culture. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report. The overall rating for the service has changed from Good to Requires Improvement. 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 Chaxhill Hall 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/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 breaches in relation to safe care and treatment, safeguarding and good governance at this inspection.

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

The provider and registered manager took immediate action to reduce risks to people. However further action was needed to implement and embed the improvements needed.

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 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 always well-led.

Details are in our well-Led findings below.

# Chaxhill Hall

**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 (ICP) 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 two inspectors.

Service and service type
Chaxhill Hall 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. Inspection activity started on 7 January 2021 and ended on 11 February 2021. When we visited the service on 7 January 2021 we found the service had a Covid-19 outbreak. We made the decision to carry out only the IPC aspect of the inspection at this time, as the service was under significant pressure and was working with relevant agencies to manage the outbreak and improve IPC practices. We returned to resume the inspection on 9 February 2021, when people were out of isolation and pressure on the service had resolved.

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 who work with the service. 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 spoke with two people who used the service about their experience of the care provided. 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 spoke with nine members of staff including the registered manager, head of care, two senior care workers, care workers, the cook and a housekeeper. We spoke with the GP for the service.

We reviewed a range of records. This included six people's care records and multiple medication records. Accident and incident records and records relating to management of people's nutritional needs. We looked at three 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 the evidence found. We looked at training data and quality assurance records. We received feedback from the local authority safeguarding adults team.

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 the last inspection this key question was rated as Good. At this inspection this key question has 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.

Preventing and controlling infection; Learning lessons when things go wrong

- Recommendations for immediate improvement of IPC practices, including safe PPE disposal, were made after a visit by the local authority IPC specialist in January 2021. When we returned in February, we saw these recommendations had been followed. However, we were not assured the IPC systems were robust enough to prevent or manage a further Covid-19 outbreak effectively.
- Cleaning arrangements were insufficient to safely reduce transmission risks within the service. After the outbreak, cleaning hours had been cut by the provider before deep cleaning of the service had been completed. Cleaning records were not detailed enough to allow the registered manager to know which rooms could safely be left open. The cleaning products in use were suitable for Covid-19 but limited guidance was in place to ensure staff used these effectively.
- The provider's IPC audit did not include measures introduced at the service to reduce transmission of CV-19 or to monitor compliance with national guidance. An IPC audit had not been carried out since 14 December 2021. This meant opportunities to improve effectiveness of IPC practices and reduce risks to people at the service had been lost.
- The provider had no clear outbreak plan in place to guide staff in the measures to be implemented in the event of an outbreak, such as segregating people and cohorting staff. The provider's Covid-19 risk assessment had not been reviewed regularly to ensure risks to people continued to be managed in line with national guidance.
- A review of lessons learned in relation to the management of Covid-19 outbreaks at the service had not taken place at time of inspection. Lessons learned shared by the service after the inspection did not take into account the shortfalls in cleaning, auditing, risk assessment and planning we raised to the registered manager during the inspection.

Failure to do all that is reasonably practicable to reduce the risk of spread of infection is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Immediate action was taken by the registered manager to reduce the risk of spread of infection to people. Immediate improvements to cleaning were made and improved systems were being implemented to reduce infection transmission risks, in line with national guidance.

Assessing risk, safety monitoring and management

- Risks to people were not always reviewed and acted upon in a timely manner. People's nutritional support plans had been reviewed before their weight change from the previous month was known and weight loss had not always been shared promptly with the cook. Accident reports were reviewed monthly, rather than

as soon as possible. These approaches meant there may be a delay in providing the right support to people to keep them safe.
● Support plans did always have enough detail to guide staff in providing consistent care to people when managing their anxiety or falls risks. Staff told us they did not refer to people's support plans when providing care but relied upon daily notes and handovers. Records did not always reflect the action taken by staff to manage changes to people's nutritional needs or falls risks.
● Following our feedback to managers about accident reviews and recording, the registered manager said accident forms would be reviewed each weekday going forward. They also revised the accident tracking sheet to include more factors for analysis and follow-up action taken.

Using medicines safely
● People's medicines had not always been managed safely. One person had refused their medicines nine times within the last 11 days, but the service had not referred this to a health care professional, to ensure any risks to the person were managed. Further to our feedback, staff informed the GP, but our conversation with the GP showed the extent of the concern had not been communicated accurately to them. The GP assured us they would work with the service to put an appropriate plan in place for refusal of medicines.
● The expiry date after opening for one medicine was not known by staff but no action was taken to ensure this medicine was safe or effective. We raised this concern to the service on 9 February 2021 but no action had been taken to resolve this before we returned on 11 February.
● Accurate records for administration of creams and ointments had not been maintained and it was not possible to check whether people had received these medicines as prescribed. The registered manager introduced revised recording for these medicines during the inspection.

We found no evidence that people had been harmed however risks relating to the health safety and welfare of people had not been robustly assessed and managed. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Environmental safety checks on the environment had been completed. Emergency evacuation plans were in place and had been reviewed regularly.

Systems and processes to safeguard people from the risk of abuse
● The provider had not always responded to safeguarding incidents to ensure they were reported and investigated in line with local processes and legal requirements. Further to an allegation of abuse reported to the registered manager in August 2020, there was a delay in the service reporting this to the local authority, as required in line with local protocols. The safeguarding authority wrote to the provider in December 2020 to advise them of their obligation to investigate the concern and to involve other agencies as indicated. While people using the service had been protected from harm, the provider had failed to ensure the allegation had been reported to the police and investigated appropriately.
● During our inspection we found three safeguarding incidents dated 5/10/20, 3/2/20 and 19/2/20 which had not been reported to the local authority safeguarding team. The registered manager had taken some action to safeguard people but had not followed local reporting protocols.

Failure to establish and operate effective systems and processes to prevent abuse of service users and investigate, immediately upon becoming aware of any allegation or evidence of abuse, is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There were enough staff on duty to meet people's needs. Staffing levels were determined by the registered

manager who took into account the number of people using the service, their level of need and feedback from staff.

- People were supported by staff with the appropriate skills and experience.
- Staff had been recruited in a safe way and in line with the provider's procedures. However, proof of identity had not always been retained in the record and staff records had not been audited to ensure completeness and accuracy.

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 the last inspection this key question was rated as Good. At this inspection this key question has 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

- The registered manager was registered with CQC to manage Chaxhill Hall in May 2011. They understood and acted upon regulatory requirements but had failed to notify us of three minor safeguarding incidents. We accepted the explanation given by them and were satisfied that notifications had otherwise been sent to CQC as required.
- The provider told us they monitored the service through regular supportive conversations with the registered manager. One site visit had been conducted by the provider during the pandemic. Lack of adequate provider oversight during this highly challenging period meant crucial opportunities to improve safety of the service and reduce risks to people were missed.
- Audits had not been updated and operated effectively to monitor and improve the quality and safety of the service in line with national guidance and the provider's policies. Audits had not identified where improvement was needed and since our last inspection, the rating for the safe domain has deteriorated. Breaches of Regulations 12 and 13 were identified during this inspection, these breaches put people at risk of harm.
- Environmental safety and infection control audits had not been completed at the service since December 2020. These checks had not been done while managers were off-site during a Covid-19 outbreak in January 2021 and had not been prioritised when managers returned to work. This meant environmental risks to people, such as fire safety, may not have been identified or addressed promptly to keep people safe.
- Accurate and complete records had not always been maintained. We found gaps in recording of creams (medicines), inaccuracies and gaps in recruitment records, limited detail and gaps in care records. The provider's quality monitoring checks did not identify these recording issues.

The systems in place to monitor and improve the quality of the service had not always been established and operated effectively to maintain the safety of the service. Accurate and complete care and recruitment records had not always been maintained. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Prior to our inspection, concerns had been raised to CQC about the culture at the service from a variety of

sources. These concerns indicated staff had not always supported people in a respectful and professional way and staff were not always working in line with the provider's policies. The registered manager had acted to improve the culture at the service through disciplinary action against staff and by updating the service's confidentiality policy.

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; Working in partnership with others; Continuous learning and improving care

- The service responded positively to support offered by the local authority to make improvements at Chaxhill Hall. They worked with commissioners to support staff to manage of one person's anxiety related behaviours effectively and had implemented all recommendations made by the local authority IPC specialist.
- Records demonstrated people's relatives had been informed and updated when their relative became unwell or was injured as a result of a fall. The service had a good working relationship with the GP who complemented the staff team on their response to the Covid-19 outbreak.
- The registered manager was open and transparent in providing the evidence requested during our inspection. They took positive action in response to the feedback given and implemented immediate improvements where possible.
- The registered manager kept themselves updated through their membership of the Gloucestershire Care Providers Association. They received updates on local and national processes and guidance from the local authority and CQC.

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 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The service had not done all that was reasonably practicable to reduce the risk of spread of infection. Risks relating to the health safety and welfare of people had not always been robustly assessed and managed. |

| 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<br><br>The service had failed to establish and operate effective systems and processes to prevent abuse of service users and investigate, immediately upon becoming aware of any allegation or evidence of abuse. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The systems in place to monitor and improve the quality of the service had not always been established and operated effectively to maintain the safety of the service. Accurate and complete care and recruitment records had not always been maintained. |