Care UK Community Partnerships Ltd

Chandler Court

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
Chandler Court is a residential care home that provides nursing and personal care for up to 80 older people, some of whom are living with dementia. At the time of the inspection visit 53 people were using the service.

People's experience of using this service and what we found
People did not always have risks to their health and welfare effectively managed. Care plans and risk assessments did not always reflect guidance and advice from professionals. People did not always receive their medicines in line with the prescription.

Audits were not always effective in identifying where actions were needed to improve the assessment and monitoring of risks and did not effectively monitor the outcomes for people.

People were protected from the risks of COVID-19 by effective infection control procedures. Staff had training in relation to COVID-19 and had access to sufficient supplies of personal protective equipment (PPE). The registered manager and provider ensured that staff were kept up to date with infection control procedures that reflected current government guidance.

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.

There were systems in place to identify any potential signs that people were unsafe or at risk of avoidable harm, however these systems were not always effective in identifying these risks. Staff understood their responsibilities to keep people safe.

People told us they felt safe and were happy with the care they received.

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.

Why we inspected
We received concerns in relation to the management of the service. 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 requires improvement based on the findings of this inspection.

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

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

Enforcement and Recommendations
We have identified breaches in relation to safe care and governance and management oversight of the service at this inspection.

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

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 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.

Chandler Court

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the 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 team consisted of 1 inspector, a specialist nurse advisor 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.

Service and service type
Chandler Court 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.
Chandler Court 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We sought feedback from the local authority and professionals who work with the service. 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 7 people who used the service and 3 people's relatives to gain their feedback about the service. We spoke with 7 staff including the registered manager, care staff and a regional director. 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 reviewed a range of records. This included 7 people's care records, samples of medicine records, daily records and care plans and risk assessments. We looked at 3 staff records and a variety of records relating to the management of the service, including audits and procedures.

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 good. At this inspection the rating has changed 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.

Assessing risk, safety monitoring and management: Using medicines safely

- Some people who had risks associated with their care, were not always protected from harm. For example, in 1 person's care records they were assessed as being at risk of choking, however staff we spoke with, including the registered manager and the nurse in charge were not aware of this risk, and the person was seated in their room with food, unobserved with their bedroom door closed. We raised this with the registered manager who took immediate steps to mitigate this risk by removing the food until the person could be supported and also placing the call bell in reach and opening their door.
- Handovers of clinical information relating to risks were not always effective. For example, 1 person's care records identified they couldn't eat properly due to ill-fitting dentures. There were no care plans or risk assessments and no recorded information on what steps were being taken to ensure the person was able to eat effectively and safely. We observed this person was left unsupervised with food, and staff we spoke with were unsure if the person should wear their dentures or were able to eat and drink safely without their dentures. This left the person at increased risk of choking as staff did not know about the risks and there was an unassessed risk around the impact of eating without dentures, for example the impact on the ability to chew food.
- Some people did not have their call bell in reach. A relative had recently raised this concern with the registered manager, however no action had been taken to ensure call bells were accessible to people that needed them. One person was sat in a wheelchair without the call bell in reach and with their door shut. Staff told us they carried out 'hourly welfare checks", however the records and our observations showed this was not always being completed. A subsequent walkaround with the registered manager identified where other people could not reach their call bell in case of an emergency. There were insufficient measures to ensure people had the means to ask for help when it was needed.
- Where people required medicines outside of their routine prescriptions, for example antibiotics for an infection, these medicines were not always collected or administered in a timely way. One person had a prescription for antibiotics to treat a chest infection, the prescribed medicine had not been collected from the pharmacy and this left the person without the prescribed treatment for over 2 weeks.
- The registered manager told us they had identified problems with prescriptions at particular pharmacies and were reviewing their systems. This had not yet been reviewed as during the inspection visit on 6 February 2023, we found a prescription for medicine to treat constipation for 1 person that was dated 24 January 2023 that had not been collected, meaning the person had gone without the treatment for almost 2 weeks.

The provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014

● When we arrived for the second day of inspection we found the registered manager had added checks to the call bells onto their daily walkaround, and we did not find any other people without access to a call bell.
● On the second day of inspection the registered manager told us they had scheduled meetings with the nurses after any health appointment including the GP, they said this would provide them with up to date information relating to any treatments or actions for a person's health straight after a health professionals advice had been given.
● Staff had training in medicines before they were able to administer medicines. There were comprehensive policies and procedures to ensure people received their medicines safely. People's medicines were stored safely and securely.
● People had risk assessments around medicines to assess the level of support they needed to ensure they had their medicines safely. Where people were prescribed medicine to be taken on an 'as required' basis' risk assessments and protocols were in place.

Systems and processes to safeguard people from the risk of abuse
● Staff understood their responsibilities to keep people safe. There were comprehensive safeguarding systems to ensure any reported concerns were actioned immediately. All staff received regular training on safeguarding.
● Staff were aware of the whistle blowing policy and told us they were comfortable whistle blowing if they felt concerns were not being actioned.
● People told us they felt safe. One person said, "Yes, feel safe, always people around, don't feel afraid of anything." Another person said, "Safe, staff are very good, safe from what I can see."
● The provider understood their responsibilities in reporting safeguarding concerns to the local authority and CQC.

Staffing and recruitment
● Observations showed that there were sufficient staff on duty to respond when people asked for assistance. However, staff's time was centred around the completion of care tasks, rather than being able to spend any quality time. Staff, people and relatives on the nursing floor told us they felt more staff were needed on each shift. One person said, "I'm very critical of staffing, level of need of people increased and staffing not changed much, in a morning from 08:00 to 11:30 bells ringing all the time." One member of staff said, "We only have enough staff to meet basic needs. We have raised with the manager through staff meetings, they think there is enough. We discussed the concerns raised with the registered manager and the regional director, who said they would revisit this with staff and look at how staff were deployed on shift.
● The provider's recruitment process included checks to ensure staff were of a suitable character. Staff files showed recruitment checks were robust, which included checks on staff through the Disclosure and Barring Service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● There were times when agency staff were used to cover shifts. People, regular staff and relatives had mixed experiences of agency staff. People told us they felt that agency staff needed more instruction and guidance on their needs and staff felt that care records were not always filled in by agency staff. The registered manager told us where issues were identified regarding agency staff, then these staff were not brought in again. There was an ongoing recruitment drive with the aim to cover every shift with regular staff.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of

infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were 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.

Visiting in care homes
● There were no restrictions to visiting at the time of the inspection.

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 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.

Learning lessons when things go wrong
● The provider had failed to always recognise where things had gone wrong and had therefore failed to implement improvements until this inspection. The registered manager acknowledged action should have been taken earlier and assured us they had plans to drive forward improvements.

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 requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The provider and registered manager had systems to review the quality and accuracy of care plans, manage accidents and incidents and ensure the good governance of the service. However, these were not always effective in identifying and managing risks to people.
- Potential choking risks were not known by the registered manager and this had meant measures to reduce the risks were not in place.
- The provider and registered manager had identified concerns regarding the timely collection of prescribed medicines. However, action had not been taken to rectify the issues leaving people at risk of not receiving medicines as prescribed.
- There were systems for the provider and registered manager to check, monitor and update care plans and risks assessments. However, care plans and risk assessments had not all been updated to manage risk safely. The registered manager told us the provider was supplying other managers from their organisation to assist with prioritising which people needed their care plans and risk assessments updating.
- Staff did not always feel supported. Some staff had not had a supervision for almost a year and said they did not always feel listened to. The registered manager told us the lack of a deputy manager and also a clinical lead had impacted upon staff supervisions but following the feedback they would prioritise scheduling staff supervisions and improving staff engagement.
- We acknowledged there was support from the provider for the registered manager in making improvements in the management and governance of the service. However, at this visit we found further improvement was needed as the systems in place, had not identified the shortfalls we found which had potential to put people at unnecessary risk of harm.

The provider's systems and processes had failed to robustly assess, monitor and improve the quality and safety of the services and assess, monitor and mitigate the risks relating to the health, safety and welfare of service user and others. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had met the legal requirements to display the services latest CQC ratings in the home.

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

● There were systems to ensure staff were involved and engaged in how the service performed. The registered manager told us, staff meetings were held so staff had the opportunity to listen to and feedback about the home. Staff meetings took place about staff practice and any improvements required.
● The registered manager told us that as things eased following the restrictions of the pandemic, plans were in place to schedule 'face to face resident and relative meetings.' The registered manager told us that they felt this was important to promote an open culture that listened to people's feedback.
● We could see people in the home had a good relationship with the registered manager. Conversations were positive and people appeared pleased to see the registered manager on their regular walkaround the service. The registered manager took time with people and encouraged them to give feedback about how they were feeling. People we spoke with were positive about the registered manager, 1 person told us, "Manager is easy to talk to", another person said, "Manager is ok, they come and speak with me."
● Staff said they treated everybody equally and there were no barriers regarding any protected characteristics. All staff had training on equality, diversity and human rights.

Working with others
● The registered manager worked with other healthcare professionals to support good outcomes for people. For example, speech and language therapists, dentists and doctors. People told us that if they were unwell the doctor was contacted, and people had a range of different health professionals involved in their care including, speech and language therapists and doctors.

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 registered manager understood their responsibility to be open and honest when things had gone wrong.
● The registered manager was open with us during our visit, telling us what they had identified and improved, equally what still needed improvement and what their plans were to achieve this. Immediately following the inspection, the provider shared a list of priority actions and assured us they would keep them updated and continue to share their actions with us.
● Some relatives told us response times to some complaints could be improved, but once responded to, the registered manager was open and approachable. One relative told us how they felt it was positive that face to face resident and family meetings were being planned by the registered manager.

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 12 HSCA RA Regulations 2014 Safe care and treatment Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems and processes had failed to robustly assess, monitor and improve the quality and safety of the services and assess, monitor and mitigate the risks relating to the health, safety and welfare of service user and others.