Stowcare Limited

Chilton 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
Chilton Court is a residential care home that does not provide nursing. Chilton Court accommodates up to 47 people who require support with their personal care needs, some of whom are living with dementia. There were various forms of accommodation provided such as houses, flats and bedrooms. At the time of this inspection there were 36 people using the service.

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.

People's experience of using this service and what we found
Not everyone had a sufficient and detailed care and risk management plan in place. This meant staff had not been provided with formal guidance as to the care support needed and how to identify specific risks to people's health, welfare and safety.

Whilst people were supported by kind and caring staff, there were insufficient numbers of staff to meet people's needs in a timely manner overnight. The provider took immediate action to address this.

People were protected from the risk of abuse because the provider had effective safeguarding systems in place. Overall, effective systems were in place to prevent and control the spread of infection with the exception of some dirty equipment and light pulls.

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.

Whilst audits in place had identified some of the shortfalls we found at this inspection, progress on rectifying these concerns was slow. The provider had not ensured there was adequate oversight of the service. Quality assurance systems and processes did not identify or address all of the issues found during this inspection.

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 16 July 2018)

Why we inspected
This inspection was prompted by a review of the information we held about this service.
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.

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 full report.

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

Enforcement and Recommendations
We have identified breaches in relation to the safe management of risk, recruitment of staff as well as the provider's governance 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.

Chilton 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
This inspection was undertaken by 4 inspectors across the 2 days of the inspection. The inspection team also included an Expert by Experience who made telephone calls to people and their relatives. 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
Chilton 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. Chilton Court 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 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 on both days.

What we did before the 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 and had contact with 9 people who used the service and 1 relative about their experience of the care provided. We spoke with the registered manager, provider, head of care, kitchen staff, housekeeping staff and care staff during our inspection visit.

Following the visit, we had email or telephone correspondence with a further 13 relatives and 8 staff members.

We reviewed a range of records. This included 8 people's care records and multiple medication records. We looked at 4 staff files in relation to recruitment and staff supervision. We reviewed records relating to the management of the service including quality assurance monitoring and the services policies 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 were not always safe.

Assessing risk, safety monitoring and management

- Improvements were needed to people's care plans and risk management plans to ensure clear guidance was provided for staff in how to meet people's needs and reduce risks to people's safety. People's care plans and risk assessments did not always give staff all the information they needed on how to safely care for people. This included a lack of dementia care plans where people were living with advanced dementia.
- People's food and fluid levels were not consistently monitored. Records contained multiple gaps which did not show people had received regular food or drink, particularly where they were at risk of, or had already experienced, weight loss.
- Where a person had lost a significant amount of weight, this risk was not detailed as the person had no nutritional care plan. This meant staff were not advised on what support the person required and any action to take if the person was to lose weight.
- Fire safety records contained a number of gaps where checks on the system had not been undertaken in line with the provider's policy.

In relation to the above shortfalls, we found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate the management of risk was effectively managed. This placed people at risk of harm.

This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

Staffing and recruitment

● The provider did not always ensure there were sufficient numbers of suitable staff overnight. We were concerned that there were not enough staff to keep people safe and meet their care needs during the nighttime. The provider took immediate action during the inspection to increase the staffing levels overnight.

● We received some mixed feedback about the staffing levels. Some relatives told us they were concerned that staffing levels were lower at weekends and not sufficient to meet people's needs in a timely manner. One relative said, "There are a lot less staff around on Sundays and often [people] are left unsupervised in the lounge."

● During our visit, we observed that there were sufficient numbers of staff on shift to spend time with people at frequent episodes during the day. Staff were not task orientated and were available and interacting with people. The provider did source one additional staff member to work during the inspection to support the team but had informed us that they were doing so. We took this into account when making our judgement.

We recommend the provider continues closely monitoring and reviewing staffing levels using an effective tool and through communication with people using the service, relatives and staff to ensure people's needs continue to be met in a timely manner.

● During our inspection we requested to view staff recruitment records. We found the provider did not have a robust system for oversight of recruitment and we therefore could not be assured that staff were consistently safely recruited and that risks associated with positive Disclosure and Barring Service (DBS) checks were reviewed. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. We have reported on this in the key question of 'Well-Led'.

● Some staff told us they felt the team would benefit from additional training in dementia and supporting people who might become distressed. One staff member told us, "We haven't had a lot of dementia training. At our last staff meeting we said we would like to have more. Some people's needs are becoming more challenging, and we need that training."

We recommend that the provider reviews the training provision available to staff to ensure it meets their needs and equips them with the skills and knowledge they need to support people effectively.

Using medicines safely

● People told us they received the support they required with their medicines. We found, however, that for one person, medicines that were prescribed to be administered 'when required' were administered routinely. This meant people were at risk of not receiving these medicines in line with the prescribers' instructions. Guidance available to staff on when 'as required' medicines should be administered was not always clear. We raised our concerns with the registered manager who took action to review this.

● Medicine management policies and procedures were in place. Medicines were ordered and safely stored. People each had they own individual lockable medicines cabinet in their bedroom.

● Staff had received medication training.

Preventing and controlling infection

● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. Most areas of the service were visibly clean, however, the underside of some pieces of equipment was soiled and many light pull cords were heavily soiled. The registered manager told us they would take immediate action to address this.

● We were somewhat assured that the provider was preventing visitors from catching and spreading infections due to the equipment requiring cleaning.
● We were somewhat 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
● The registered manager was following current government guidance in relation to visiting at the time of the inspection. People and their relatives told us there were no restrictions on visiting.
Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe living at Chilton Court and that they could speak up if worried about something. One person told us, "The staff treat me very well, they are all nice."
● Safeguarding concerns were reported appropriately. Information about how to report concerns was available to staff and visitors.
● Staff had received training and knew what to do if they had concerns about abuse. One staff member said, "I know how to raise a safeguarding concern and would feel comfortable doing so. We also have a whistleblowing procedure which encourages [staff] to come forward if they are ever concerned about something at work. This also gives us the right to follow up this report and make sure the appropriate action has been taken."

Learning lessons when things go wrong
● The registered manager had systems in place to monitor incidents and accidents, however, these were not always used proactively and effectively.

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

- Risks to people as referred to within the safe section of this report had not always been fully assessed and recorded. There was a failure to maintain accurate and fit for purpose care records and ensure effective governance systems.
- A range of audits and checks were in place. However, they had not been effective in ensuring that all issues found during the inspection had been identified and acted upon prior to our inspection. These issues were found in the areas of medicines, infection control, care plans, safety and maintenance of the premises, training, and recruitment.
- We could not be fully assured staff were safely recruited, a lack of completed and recorded risk assessments did not demonstrate adequate registered manager or provider oversight of the recruitment processes in use.

Systems designed to monitor the safety and quality of the service and take action to mitigate risk, were not robust. 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

- We received differing views from people's relatives about the culture at the service. Some relatives were positive, and others had concerns about the way the care home was being run currently. One relative told us, "I don't think I would recommend it as it currently stands." and "Raising concerns doesn't always resort in things being rectified." Another relative commented, "I do see [registered manager], they are very nice. 'I've no complaints or concerns."
- Staff morale was mixed. Some staff spoke of supportive hands-on management support, whilst others told us there was a lack of support and challenges. One staff member said, "Communication is terrible, it's the worst it's been lately." Another staff member told us, "There is no leadership, no organisation and things keep changing all the time. I do not feel comfortable in raising my concerns as I don't feel I would be taken seriously and in the past any concerns I've had nothing has been done."
- Some staff were positive about the support they received. One told us, "The leadership at Chilton Court is brilliant. There is always someone to be able to go to, questions are answered to the best of their knowledge and support is always given. I know that there is always somebody I would feel comfortable in going to speak to."

● We observed a kind and caring culture at the service. Staff were attentive and were respectful in their interactions. One relative told us, "My [family member] is happy and has an excellent relationship with the care and support staff."

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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others

● Duty of Candour processes were followed. The registered manager was transparent and alerted relevant people when things went wrong. People and their relatives were involved in discussions and actions undertaken collectively.

● The registered manager had informed healthcare professionals, people and their relatives if concerns about people's care had been identified. This was in accordance with the duty of candour.

● The provider worked in partnership with others. People were referred to health and social care professionals, and the management team knew how to go about seeking community support for people.

● The provider was aware of their obligations for submitting notifications to CQC, as required by law.

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 The provider failed to assess and monitor the risks to the health and safety of people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate a robust system to monitor the quality and safety of the service provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.