Optima Care Limited

The Chilterns

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inspected but not rated**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
The Chilterns is a residential care home, that accommodates up to 26 people in three adapted adjoining buildings. At the time of the inspection there were 19 people living at the service, who needed support with their mental health, or living with a learning disability .

People's experience of using this service and what we found
People were at risk from themselves and each other. Incidents occurred between people, one person told us they did not feel safe in their own home. The provider had not learnt from these incidents, and similar incidents re-occurred as a result placing people at harm. Staff did not have the skills, knowledge or training to deal with the very complex needs of people they were supporting. There was a lack of guidance for staff to follow, and where guidance was put in place it had not always been shared with agency staff. People had been unlawfully restrained by staff. Staff placed unlawful restrictions on people.

Risks relating to people's health had not been managed; people were at risk of constipation and were not supported to manage this safely. Staff lacked the knowledge of how to support people when incidents occurred, for example when people sustained head injuries and as a result there was a delay in seeking medical advice.

Infection prevention control measures were not adequate. The service was not clean and well maintained; there were various holes in walls and doors and skirting boards and walls were dirty and in need of decoration. One staff member was observed frequently without a face mask, not in line with government guidance regarding the prevention of Covid-19.

There was a lack of leadership and oversight from the provider. Audits and governance systems had failed to identify unsafe practices raised in this inspection. The quality of audits completed was poor. The provider failed to identify that they were not meeting their regulatory responsibilities. Safeguarding incidents were not always raised with the local authority safeguarding team. Statutory notifications were not raised with the CQC, and the service was not complying with the Mental Capacity Act.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

This service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture. People had unnecessary restrictions placed on them, which infringed their human rights. Staff used punitive measures to restrict and control people's personal belongings.
Right support:
• The model of care and setting did not maximise people's choice, control and independence.
Right care:
• Care was not person-centred and did not promotes people's dignity, privacy and human rights.
Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using services lead confident, inclusive and empowered lives.

This meant people were placed at harm; had unnecessary restrictions placed on them and did not receive person centred care. The provider had not acted or taken any measures to mitigate the risk of harm to people or support people to live with choice or independence.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)
The last rating for this service was requires improvement (published 1 October 2018) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made/ sustained and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about incidents between people, allegations of abuse and staff competencies. A decision was made to inspect and examine those risks. 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. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe, effective and well led sections of this full 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 The Chilterns on our website at www.cqc.org.uk.

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.

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 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, staffing, fit and proper persons employed, premises and equipment, consent, notifications and good governance at this inspection.

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 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.

Special Measures
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 effective?

Inspected but not rated

At our last inspection we rated this key question Requires Improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

The Chilterns

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 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 inspection managers, two inspectors and a mental health act reviewer.

Service and service type
The Chilterns 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 did not have a manager registered with the Care Quality Commission. This means that the provider is 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.

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 and professionals who work with the service. We did not request the provider to submit a provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information

helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with seven people who used the service. We spoke with 11 members of staff including the manager, senior care workers, care workers and the activities lead. We reviewed a range of records. This included eight people's care records and multiple medication records. 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 evidence found. We looked at training data and quality assurance records.

Inadequate

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 Requires Improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to consistently assess the risks to the health and safety of some new admissions to the service and do all that is reasonably practicable to mitigate risks. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- At our last inspection in August 2018 risks assessments for new admissions had not been completed. At this inspection, we found no improvements; risk assessments were not always in place or up to date for most people.
- Risks to people had not been managed and as a result people had suffered harm. One person fell and hit their head. Staff did not take any action at the time of the fall and a health check of the person was only requested four days later when the incident was reviewed by the manager. On another occasion a person fell and hit their head. There was no immediate action by staff to seek healthcare support. The person was taken to hospital for review 24 hours after the incident occurred.
- Some people were at risk of constipation. There was no support plan or guidance in place to inform staff on actions to take should people become constipated. One person had been hospitalised with a blockage in their bowel. There was no monitoring in place to support people with their health needs.
- One person was at risk of falls. They did not have a falls risk assessment or care plan in place. The person told us they fell down the stairs and two falls were recorded; however no action had been taken to reduce the risk of further falls.
- One person was at risk of weight loss. There was no care plan or risk assessment in place to support the person with the known risks. The person had not been weighed in over a year so staff could not be assured the person had not lost weight or needed further professional health input.
- Some people could show self-injurious behaviours. Risk assessments and care plans were not clear or detailed enough to support people with these known risks.
- Incidents between people had not been de-escalated by staff and people were at risk from physical abuse. There had been incidents were people physically assaulted other people living at the Chilterns, and staff. Action had not been taken to reduce the risk of incidents re-occurring. Lessons were not learnt from incidents to protect people from harm.
- Not all incidents were recorded. For example, staff described an incident to us where a person had been

displaying behaviours that were challenging. Up to eight staff members were involved in restraining the person. This incident had not been documented, therefore the provider was unable to review the incident and analyse this to reduce the risk of the incident reoccurring.

Preventing and controlling infection

● One person had known risks around infection control. There was no clear guidance in their file for staff to follow detailing how to support the person cleaning their room, and where cleaning products and PPE (personal protective equipment) was kept for staff to use.

● People were not protected from the risk of infection. The service was not clean, for example the toilet walls on the ground floor were visibly dirty. There was one cleaner working across three houses that worked part time. The provider had not reviewed staffing levels in relation to cleaning frequently touched areas and increasing the frequency of cleaning due to Covid-19.

● We observed one staff member not to be wearing their mask on three separate occasions during the inspection. The staff member told us they had a mask but were observed not to be wearing it.

● Staff did not understand the current government guidelines in place for Covid-19. For example, one staff told us people could only leave the service for essential shopping, however later during the day we observed staff and six people leaving to play cricket. This was not in line with current guidance around Covid-19.

The provider failed to assess the risks to the health and safety of people, doing all that is reasonably practicable to mitigate risks. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, the provider moved one person to another part of the building and reviewed the staffing in place to support this person.

● Environmental checks had been completed, for example a recent fire drill had taken place, and there were weekly fire checks completed to ensure equipment was working correctly.

Staffing and recruitment

At our last inspection the provider had failed to provide sufficient numbers of staff consistently to meet people's needs and keep them safe. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● There were not always sufficient numbers of staff to meet people's needs and keep them safe. The manager informed us depending on people's needs, and the contracted hours commissioned by the local authority the service needed between 13 and 15 staff on a daily basis. Rotas reviewed showed that each day there should have been 15 staff members on shift each day. However, daily allocations of actual worked shifts showed as little as 10 staff on most days, this included agency staff. The manager was unable to demonstrate the hours contracted by local authorities had been met.

● The service was supported by some agency staff. The manager informed us agency staff had opportunities to review people's care plans before providing them with support. However, staff told us that positive behaviour support plans were not shared with agency staff.

● Staff did not have the relevant knowledge skills and experience to support people with complex needs. The manager informed us most of the people at The Chilterns needed support with their mental health,

however none of the staff had received training in mental health.
● Some people could display behaviours which could be challenging to others. Most staff had not received training in positive behaviour support (PBS). Staff told us there were no competency checks on staff to ensure they understood positive behaviour support plans. Records showed that some people had been restrained whilst living at The Chilterns. Not all staff had been trained how to safely restrain people.

The provider failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff is a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● When new staff started working at the service, the relevant checks were not always completed to make sure staff were of good character to work with vulnerable people. For example, gaps in work history had not been explored by the provider. Suitable references had not always been sought.

The provider failed to ensure that persons employed were of good character and to ensure recruitment procedures were operated effectively. This is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014

Systems and processes to safeguard people from the risk of abuse
● Staff we spoke with did not have a good understanding of safeguarding issues or concerns; training records confirmed not all staff had completed safeguarding training. Staff had no knowledge of recent safeguarding incidents.
● People were at risk of and had been harmed by other people living at the Chilterns. Following a physical altercation between two people which resulted in one of them needing medical attention, no steps had been taken by staff to protect either person. One person told us they spent most of their time in their bedroom, as they were scared of someone they were living with. No action had been taken to protect this person from the risk of abuse.
● People had been unlawfully restrained by staff. Incidents of restraint had not been reported to external agencies such as the local authority safeguarding team. Following incidents of restraints, the providers incident reports stated that observations should have taken place on people, but we found this was not the case. Restraint should always be used as a last resort; we found other measures to de-escalate situations had not been carried out by staff.
● People were at risk of financial abuse; some staff had people's bank cards and pin numbers. Best interest meetings had not been undertaken to decide if it was in people's best interest for staff to have access to their money. Notices within the service detailed that people would be fined £5,000 for failing to shut their bedroom doors. Staff told us that people were asked to keep their doors shut to protect their personal belongings. People told us that staff would enforce this penalty.
● The manager and provider failed to identify safeguarding incidents. They did not understand their responsibilities in relation to reporting safeguarding incidents to the local authority safeguarding team.

The provider failed to protect people from abuse and improper treatment is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Using medicines safely
● People received their medicines when required and as prescribed.
● Some people needed 'as and when' required (PRN) medicines. PRN protocols were in place and detailed why they needed the medicine and what the maximum dosages were.
● Medicine administration records (MAR) had been fully completed by staff.

Inspected but not rated

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires Improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to review a specific concern we had about mental capacity and deprovision of liberty. We will assess all of the key question at the next comprehensive inspection of the service.

Adapting service, design, decoration to meet people's needs

At our last inspection the provider had failed to properly maintain the service. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 15.

● At the last inspection in August 2018 we identified that the dining room ceiling had collapsed and work to repair it had not been timely. People were unable to use the dining room, and this impacted on their ability to access certain areas of the service. At this inspection, we found the dining room ceiling had been fixed. However, other areas within the service had not been well maintained, and this had an impact on people's wellbeing.
● The service was not well maintained throughout. For example, there were numerous holes in doors and walls throughout the service including communal areas. This did not provide a homely environment for people living at the service.
● Parts of the service were in need of re-decoration as maintenance had not kept up with the rate of wear in the service. Staff confirmed that maintenance had not been affected by the Covid-19 pandemic, but by the volume of work to complete, and the resources and time they had.
● It was difficult to clean parts of the service effectively due to the state of repair. This increased the risk to people due to the current pandemic and the importance of maintaining high levels of infection control.

The provider had failed to properly maintain the service. This is a continued breach of regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Act 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 MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Staff and the manager did not understand the principles of the MCA. Unlawful restrictions were in place which infringed on people's human rights.
- When people lacked capacity staff had not ensured appropriate procedures had been followed. For example, one person was deemed to lack capacity to manage their finances. There was no evidence that decisions taken to determine the least restrictive way to support the person with their finances had been taken in their best interest. There was no evidence that any best interest meetings had been held or documented.
- People had been deprived of their liberty without any authorisations in place to do so. For example, the doors were locked at the service, and no one could leave without support from staff. Staff were not aware of who could leave the service unsupported and who needed supervision from staff when going out.
- Some people had prevention or protection orders in place. Senior managers had put in place a blanket approach that these people would not access the community independently. However, there was no legal authority to prevent people from accessing the community independently.
- People had unnecessary restrictions placed on them. For example, one person was told if they did not follow the rules in place they would lose their personal belongings. The person had capacity and staff had no legal authority to remove their possessions.

The provider failed to implement consistent practice with regard to obtaining and documenting consent for care and support. This is a breach of regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated 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.

Continuous learning and improving care

At our last inspection the provider had failed to consistently assess, monitor and mitigate risks to people's health, safety and welfare. The provider had failed to maintain accurate and complete records for each person. The provider had failed to improve the quality of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● At our last inspection in August 2018 the provider had failed to assess monitor or mitigate risks to people's health, safety and welfare. At this inspection we found risks continued not to be assessed, and further issues identified in this report had not been identified or addressed by the provider or manager.
● There had been a lack of learning and implementing positive change within the service. Since our last inspection in August 2018 there had been a lack of improvement, and the service is now rated inadequate.
● Following incidents between people, the provider and manager failed to review and update care plans and to identify that there was a lack of guidance for staff to follow in order to de-escalate situations.
● Audits of care plans had not identified that information was incomplete or out of date. For example, one person's care plan stated they could and could not communicate verbally.
● We recently inspected other services registered to the provider and had identified themes regarding the monitoring of quality and safety across multiple services. Despite this, the provider had not carried out a recent quality audit of The Chilterns to check the quality of the service. The last audit was carried out in November 2020. We requested a copy of this document but this was provided significantly after requested, and not in a format we could review.
● There was a lack of effective governance and oversight. Significant shortfalls identified at this inspection had not been identified by the providers governance and oversight policies, which had enabled poor practices to be continued.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● There was not a positive culture within the service; we identified a closed culture. A closed culture means a poor culture that can lead to harm, which can include human rights breaches such as abuse.
● People's human rights had not been upheld. People were subject to punitive consequences if staff did not

agree with actions or behaviours they displayed. For example, people's belongings had been threatened to be removed if they did not comply with certain rules.

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

- People told us that their feedback had not been acted on. For example, one person told us they wrote a letter to the manager to tell them they did not feel safe living at the Chilterns. They did not receive a written response from the manager, and no action had been taken to address their concerns.
- The manager and provider had not sought support from external health care professionals when serious incidents occurred between people, to seek additional support in relation to behaviours which had challenged people and staff.

The provider failed to consistently assess, monitor and mitigate risks to people's health, safety and welfare. The provider had failed to maintain accurate and complete records for each person. The provider had failed to improve the quality of the service. This is a continued breach of regulation 17 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider failed to meet their regulatory requirement to inform us about incidents that had occurred at The Chilterns. The provider and manager lacked the understanding of regulatory requirements.
- The provider failed to ensure legislation was complied with. For example, they failed to identify that they were unlawfully restricting people and infringing people's human rights. The provider failed to identify that best interest meetings and mental capacity assessments had not been completed.
- The provider and manager failed to be open and honest sharing information with relevant stakeholders including people, relatives, the local authority safeguarding team or the CQC.
- There was not a registered manager in post, the last registered manager de-registered in April 2019, however the manager had submitted an application to become registered with the CQC.

The provider failed to notify the CQC of safeguarding incidents which is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.