Chilton Care Homes Ltd

Chilton Croft Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Chilton Croft Nursing Home is a residential service providing personal and nursing care for up to 32 people, some of whom are living with dementia, in one adapted building. At the time of our inspection there were 29 people using the service.

People's experience of using this service and what we found
Risks to people's health, safety and welfare were not managed effectively, placing them at risk of harm. We found large gaps in staff recording of support provided to people at risk of acquiring pressure wounds and inadequate fluid intake. The failure to follow risk assessments and ensure that people were assisted to reposition at regular intervals placed people at increased risk of skin breakdown. Medicines were not always safety stored.

People were at risk from a lack of trained and competent staff to meet their needs at night. There was one nurse and two care staff on duty to respond to people with a wide range of complex needs. We found that fire safety procedures were unclear, and staff did not have access to the information they needed to respond in an emergency.

The provider's governance systems in monitoring the quality and safety of the service continued not to be effective and did not identify the shortfalls we found at this inspection. Risks to people's safety associated with improper operation of the premises had not always been identified and action taken to reduce these risks.

Safeguarding processes were not fully effective, and concerns were not always subject of sufficient scrutiny.

The systems within the service did not always promote people's dignity and while some training had been accessed, changes had not been embedded into the culture of the service.

Feedback from people using the service and their relatives was inconsistent and while we received positive comments about the levels of support and quality of the meals, we also heard concerns about areas such as staffing at night and people's access to meaningful activity.

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.

People benefited from a stable staff team and there was a clear process in place to check staff suitability before they started work.

Actions the provider told us they would take following our last inspection had not

been implemented. Following this inspection, the provider told us that they intended to work with a newly appointed consultant, health and Local Authority to making improvements.

Rating at last inspection and update
The last rating for this service was requires improvement (published 16 June 2021) and there was a breach 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 we found the provider remained in breach of regulations.

Why we inspected
We received concerns in relation to safeguarding incidents, the management of people's nursing care needs, staffing and oversight arrangements. A decision was made for us to inspect and examine those risks. We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements. We have found evidence that the provider needs to make improvements. 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 requires improvement to inadequate based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report and you can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Chilton Croft Nursing Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to risk, staffing safeguarding and 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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Chilton Croft Nursing Home

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 carried out by three Inspectors.

Service and service type
Chilton Croft is a 'care home' which provides nursing care. 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.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post who is also a director of the registered company.

Notice of inspection
This inspection was unannounced.

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 and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
The inspection team visited the service over two days, which included the early morning, afternoon, evening and night shift. We conducted care observations and review of records including staff recruitment records, care plans, incidents and audits. We spoke with three people who used the service and seven relatives. We also spoke with three nurses, eight care staff, the clinical lead, quality lead, general manager, the cook and the registered manager.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed 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

- The provider failed to ensure people were protected from the risk of avoidable harm. One person's pain had not been escalated in a timely manner which lead to deterioration in their wellbeing.
- Risk assessments were in place for people who had been identified as being at risk of acquiring pressure wounds. However, we found that these were not all up to date or followed by staff. People spent significant periods in sedentary positions without mobilising and there were gaps in repositioning records of up to 12 hours. The failure to follow risk assessments and ensure that people were assisted to reposition at regular intervals placed people at increased risk of skin breakdown.
- People were at risk of inadequate fluid intake as their intake was low and monitoring was ineffective. People were observed not always having access to a drink and records were poorly maintained. There were no clear fluid targets to provide staff with the information they needed to meet people's needs.
- There was a lack of safety monitoring and we found the majority of people did not have access to a call bell during the night time period. There was no assessment as to people's capacity to use a call bell or alternative arrangements in place should they need staff support. Staff told us they carried out hourly checks during the night but there were no records of checks maintained to evidence this.
- Risks to people's safety in the event of a fire had not been fully considered. Staff lacked the skills and knowledge to respond in the event of an emergency, such as outbreak of fire.
- We found staff on duty on the night of our inspection had not been trained to know what procedures were in place to respond in the event of a fire. The nurse in charge who would be the lead person to instruct staff should the fire alarm sound, did not know the location of the fire alarm panel which we found located in a cupboard. There was no access to written fire safety procedures for staff with steps they should take to ensure people's safety.
- Personal evacuation plans (PEEPS) were not available to night staff to enable an evacuation in the event of an emergency. The general manager told us these were in a locked office which night staff did not have access to. During our inspection we requested the provider take immediate action to train the staff on duty to ensure they had the required knowledge and competency to respond in the event of a fire outbreak. We also raised a safeguarding alert with the local authority safeguarding team as well as notifying the Suffolk Fire Service of our immediate concerns.
- Risks to people's safety associated with improper operation of the premises had not always been identified and action taken to reduce these risks. We found people were at risk of scalding from hot surface radiators and exposed pipework in people's rooms and en-suites.

Using medicines safely

- Prescribed medicines were not always stored safely which placed people at risk of harm. We found three tubs of thickener and prescribed creams in one room recently vacated. This room was found unlocked,

located just off the communal lounge where people had access. A senior member of staff told us, "This room should have been locked." We requested the items be removed immediately.
● Where people were prescribed creams and lotions care staff administered these medicines. We found the majority of topical medicines charts did not provide care staff with instructions for administration as prescribed.
● Topical medicines charts completed by care staff showed people did not always receive their medicines at the regularity prescribed. We noted creams and lotions prescribed for people at risk of acquiring pressure wounds were not always administered at the regularity required.
● We found a number of prescribed creams not dated when opened as required.

The shortfalls in the management of risk and the oversight of medicines demonstrated a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

Staffing and recruitment
● There were insufficient staff deployed to meet people's needs in a safe and effective manner. At our last inspection concerns regarding night staffing were identified but we were assured by the provider that additional staff had been provided.
● At this inspection we found that previous staffing levels had not been maintained and there was no longer a twilight shift. At night we found that there was one nurse and two care staff to support 29 people. We observed multiple occasions where staff were trying to support people who had high level support needs and who were at considerable risk of harm whilst also trying to complete other care tasks. One person for example was distressed and repeatedly called out for assistance but staff did not respond as they were working on a different floor of the service assisting others.
● Night staff told us at least 20 of the 29 people living in the service at the time of our inspection required two staff to support with personal care during the night time period. They also told us there was insufficient staff available to monitor people who required constant supervision.
● One person required one to one support and constant staff observation as they were a risk to themselves and others. We observed several occasions where staff deployed to provide constant observation were called away to answer call bells. Staff also told us they were not managing to ensure constant observation for this person whilst meeting the needs of others.
● We noted people cared for in bed were not engaged in any meaningful activity by staff. Many people were disengaged or displayed distressed behaviours. Staff told us that after the evening meal they assisted people in the communal areas to bed. Staff were observed to be busy and we observed 22 out of 29 people in residence were in bed by 7pm. It was not clear if this reflected the deployment of staff or people's preferences as not all care plans showed people had been consulted as to the times they wished to go to bed.
● We received inconsistent feedback about staffing from relatives and people using the service. Some people told us they liked the fact that they were supported by a stable staff team. Others expressed concerns about the availability of staff at night and the lack of meaningful activity for their relatives who were in bed.
● Following the inspection, the provider submitted a dependency scoring tool which indicated that overall staffing levels were above those recommended. However, we were not assured that inputs into the system were up to date or that it took account of other factors such as staff deployment.

The provider had failed to ensure there were sufficient numbers of suitably trained and deployed in the service. This placed people at risk of harm and is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Checks on staff suitability were undertaken on all new staff prior to their appointment. Identity checks, criminal records check, and appropriate references had been obtained on newly appointed staff.

Systems and processes to safeguard people from the risk of abuse
● Safeguarding processes did not work effectively to ensure that people were adequately protected. At the last inspection we identified shortfalls in the reporting of safeguarding concerns. At this inspection we found that while staff had been provided with additional training, this was not yet embedded.
● A whistle blower had raised some concerns to the senior management team about staff practice within the service but there was no evidence that this had been subject to sufficient levels of scrutiny by the provider. The local authority were conducting investigations into alleged safeguarding incidents but we were not assured that the provider understood the seriousness of the concerns.
● The provider had not informed CQC of the ongoing safeguarding investigations as required through formal notification.
● Not everyone using the service were able to verbally communicate their wishes and feelings. Systems and processes did enable support for them to raise any concerns or complaints should they have any.

This shortfalls in safeguarding processes placed people at risk of harm and is a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. We found equipment such as bedrail covers which were soiled, hoists which were in need of cleaning and a suction machine which was dirty stored on the floor of the medicine's rooms on the two days of the inspection. Infection control audits had not been undertaken on a monthly basis in line with the provider's policy.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● 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 accessing testing for people using the service and staff.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

We have signposted the provider to resources to develop their approach

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 checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- 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.
- Where people required medicines to be administered covertly, required authorisations were in place.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider had failed to demonstrate safety was effectively mitigated and lessons were learned to prevent future incidents assess the risks relating to the health safety and welfare of people. 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.

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

- The provider had failed to ensure the service was well-led and as a result people were at risk of not receiving good and safe care.
- There continued to be a lack of oversight to ensure safe care was being provided to people. For example, identifying risks to people from hot surfaces such as unguarded radiators, unsecured wardrobes, a lack of staff training in responding to emergencies such as fire and a failure to identify medication concerns. Some checks were completed but these were not robust.
- Quality assurance was not embedded into the provider systems and used to drive improvement. Care plans were not consistent, accurate or kept up to date to give staff the instructions they needed to provide personalised care. Care provided was task focused as evidenced from observations, staff discussions and recording in daily notes. The providers systems had not evaluated care delivery and failed to identify the shortfalls we found.
- There was a failure to maintain accurate and complete records to demonstrate that people were receiving the care and support they required. For example, there were no recorded night time checks to ensure people were receiving their assessed care. Care plans were not consistent, accurate or kept up to date to give staff the instructions they needed to provide personalised care. Audits of care records were not being consistently completed and therefore the provider did not have an effective system to drive quality improvement.
- The providers systems to assess and monitor staffing levels were not effective. They had not identified shortfalls in staffing particularly at night or identified that the ineffective deployment of staff led to poor communication and outcomes for people. There was a lack of transparency regarding staffing and staff including senior staff were not clear about who was in receipt of enhanced hours, what this meant for people and how it was managed.
- The provider had not created a culture of high quality care and a focus on improvement. Opportunities provided to improve outcomes for people had not brought about change. Training had been organised by local authority on the promotion of dignity within the service however practice had not significantly

improved. We observed disrespectful comments and poor practice such as staff neglecting to communicate with people when supporting them with eating their meals and mobilising whilst using a hoist. The provider had not ensured that support to improve and been embedded and could be demonstrated through audit tools such as spot checks, staff observations or dignity audits.

● There was a failure to act on and make improvements, for example at the last inspection we found that the inspection rating was not clearly displayed, and we were assured by the provider that this would be rectified. However, at this inspection we found that improvements had not been made.

● Other action the provider told us they would take following our last inspection had not been implemented. This included planned improvements to audits, the monitoring of people at risk of acquiring skin wounds and improving the mealtime experience.

● A new clinical lead was in post, but the role of the nominated individual was not clear and the leadership structure did not enable systems to be embedded to ensure a robust oversight of quality and staff supervision.

The continued failure to understand assess, monitor and mitigate risks, to maintain accurate and fit for purpose care records with ongoing plans to ensure improvement of the service demonstrated a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Opportunities had been missed to identify ways of preventing future incidents. Safeguarding investigations did not always include findings with lessons learnt to prevent the risk of future harm.

● Throughout the inspection the provider demonstrated a lack of understanding in relation to safeguarding investigations and processes ongoing. Information shared with families was not always timely or sufficiently detailed to show a full review of concerns had been implemented. The provider had not informed CQC of the ongoing safeguarding investigations as required through formal notification.

● Following recent safeguarding incidents, and our findings from this inspection the provider told us that they were working with the local authority and external health colleagues to make improvements needed in quality and safety. Reviews were established to consider the care model required to ensure peoples assessed support hours were met safely.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The provider had failed to ensure people were receiving care that met their individual needs.

● Areas of risk were not being effectively monitored and health and well-being of people living at the service was not routinely assessed.

● Most relatives knew the provider and told us that they were approachable. Comments we received from staff included, "I like the manager, but he doesn't really manage the home. He flits here and there." And, "I would say he is approachable, but he doesn't really have a handle on what needs to be done. Things constantly change, one idea to another." There was no evidence of a formal system to gather and analyse feedback from people using the service and relatives.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment This shortfalls in safeguarding processes placed people at risk of harm and is a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.