Optima Care Limited

The Chilterns

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Chilterns is a residential care home, that can accommodate up to 26 people in three adapted adjoining buildings. At the time of the inspection there were 13 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 told us they were not always happy with the staff supporting them. When safeguarding incidents occurred, care plans and risk assessments had not been updated to reflect any changes in risks to the person. Care plans and risk assessments did not always contain the information necessary to inform new or agency staff on how best to support people. Incidents between people had reduced as a result of people moving on from the service, and a review of staffing. Accident and incident analysis were being carried out by the manager but needed improvements to ensure learning was documented on people's care plans.

Medicines management was not always safe. The relevant supporting documents were not always used to inform staff of where and how to apply medicated patches. Body maps were not in place to inform staff of where to apply medicated creams.

Checks and audits were being completed but had not always identified and resolved issues identified during this inspection. The culture within the service had improved, but there were still areas needing further improvement. The manager acknowledged there were still improvements to be made.

Staffing levels had been reviewed and a dependency tool was now in place to support how many staff were needed on each shift. We observed there to be enough levels of staff to meet people's needs.

There had been some improvements to the environment of the service. The service was clean and there was a maintenance schedule to make improvements that were still needed, such as decorating parts of the service.

People had been involved in the service, with their opinions sought and acted on. For example, sporting events were made into activities for people, with projectors and themed meals. Restrictions placed on people had been reviewed, and there were no longer restrictions placed on everyone. For example, one person had a key fob enabling them to leave and return to the service as they chose to.

People were supported to have 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.
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.

The service was able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.
Right support:
• Model of care and setting mostly maximises people's choice, control and independence
Right care:
• Care was mostly person-centred and promotes people's dignity, privacy and human rights
Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff mostly ensured people using services lead confident, inclusive and empowered lives

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 inadequate (published 24 May 2021) 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 we found some improvements had been made however the provider remained in breach of regulations. This service has been rated requires improvement or inadequate for the last five consecutive inspections.

This service has been in Special Measures since 24 May 2021. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
This was a planned inspection based on the previous rating. This inspection was carried out to follow up on action we told the provider to take at the last inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We carried out an unannounced inspection of this service on 25 March 2021. Breaches of legal requirements was/ were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, staffing, fit and proper persons employed, safeguarding service users from abuse, premises and equipment, need for consent, good governance and notification of incidents.

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, Effective and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from inadequate to well-led. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The

Chilterns on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to 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 safeguarding service users from abuse and improper treatment, safe care and treatment 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.

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.

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?

Requires Improvement

The service was not always well-led.

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
This inspection was carried out by three inspectors.

Service and service type
The Chilterns is a residential care home for people who need support with their mental health, or who are living with a learning disability, or both. This inspection focused on care for those experiencing mental ill health. We inspected for the regulated activity of 'treatment for a disease, disorder or injury (TDDI)' during this inspection. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service does not have a manager registered with the Care Quality Commission. This means 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 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. We did not request a provider information request, 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 four people who used the service about their experience of the care provided. We spoke with eight members of staff, this included the manager, operations manager, team leader and care staff.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at two 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.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Inadequate. At this inspection this key question has now improved 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.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to protect people from abuse and improper treatment. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment (Regulated Activities) Regulations 2014.

Although some improvements had been made at this inspection and the provider remains in breach of regulation 13.

- Two people we spoke with told us they were not always comfortable with the staff supporting them. One person told us, "Depends who it is, some I feel safe with but there are some I feel uncomfortable with. I'm not afraid of staff but some are better than others." We raised this with the manager who assured us they would investigate further.
- When incidents of abuse occurred, the manager had reported them to the local authority safeguarding team and the CQC. However, following incidents of abuse, risk assessments and care plans were not always reviewed and updated to highlight increased risk to people.
- Systems were not operated effectively to protect people from abuse. For example, when people had made claims of financial abuse, this was not clearly documented within their files to inform staff of the risk to the person.

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

- Since our last inspection staff had undertaken safeguarding training and competencies. We found staff had improved knowledge on safeguarding, and incidents that had occurred at the service.

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

At our last inspection the provider had failed to assess the risks to the health and safety of people, doing 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.

● Since our last inspection there had been a significant reduction in incidents between people living at the service. This was in some cases due to people being supported to move to other services, and the manager informed us reviews of care plans and risk assessments had also contributed. However, we identified risk assessments and care plans needed to be more robust to provide staff more information and guidance to be able to assist to reduce the likelihood of the incident re-occurring.
● Some people could be at risk of causing harm to themselves or others. When incidents had occurred, risk assessments and care plans had not always been updated to reflect this risk.
● One person reported to staff they were in pain due to a health condition. It was not clear what actions had been taken and what staff had completed to support this person. Following this incident, the person's positive behaviour support plan was not updated to inform staff of any changes.

Using medicines safely
● Medicines were not always managed safely. For example, the positions of pain relief patches were not recorded. These are patches applied to the skin that release a measured dose of pain relief through the skin. This made it difficult to know if a replacement patch was positioned on a different site to help prevent skin irritation, or skin breakdown. Following the inspection, the manager sent us a copy of where and how this should be completed on the new E-Mar system and assured us this would be completed.
● Some people were prescribed medicines on an as and when needed basis (PRN). When we asked to review these protocols around this staff were unable to locate these for two people. This placed them at risk of not receiving their medicines as prescribed.
● Some people were prescribed medicated creams. We found there was no guidance or instructions in place for staff to indicate where and how to apply the cream. Although most people were able to apply their own creams, during a period of ill health there could be a risk to people, of this not being applied as prescribed by staff.

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.

Preventing and controlling infection
● At our last inspection people were not protected from the risk of infection. The service was visibly dirty, and staff did not utilise personal protective equipment (PPE) in line with guidance. At this inspection the service was cleaner and staff were wearing PPE. A staff member told us, "The cleanliness has improved. We do hourly cleaning of handles and we have a COVID-19 checklist."
● 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 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.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

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.

Improvements had been made at this inspection and the provider was no longer in breach of regulation 18.

● Since our last inspection the manager took action to ensure suitable numbers of skilled staff were deployed. We observed there were enough staff to meet people's needs. Staff told us, "Yes there are enough. [Person] is on a 1-1 and this is always covered. People have moved out and there are enough staff here to support everybody well." A person told us, "I feel there are enough staff."
● Staff had received training in how to support people with their mental health, and in de-escalation techniques. One staff member told us, "I have had sufficient training (since being here). It was very thorough, very good."

At our last inspection the provider had failed to ensure that persons employed were of good character and to ensure recruitment procedures were operated effectively. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements had been made at this inspection and the provider was no longer in breach of regulation 19.

● At our last inspection we found relevant checks were not always completed on new staff members to ensure they were of good character. At this inspection, we found full employment details had been taken, with any gaps in employment explained. Suitable references had been obtained for new starters. Disclosure and Barring Service (DBS) criminal records checks had been completed for all staff before they began working at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

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.

Improvements had been made at this inspection and the provider was no longer in breach of regulation 15.

- At our last inspection we found the service was not well maintained, with holes in walls and décor not maintained to a good standard. At this inspection we found some improvements had been made; repairs needed to walls had been completed, but further work was required in relation to the decoration of the service.
- The manager had a maintenance plan detailing work needing to be completed on the service, and timescales to complete this. There was evidence the manager had been chasing companies for quotes and for work to begin. We will check the progress of this during our next inspection.
- We observed the service to be clean. There had been a concerted effort to clean areas of the service, which we had previously found to be dirty and pose an infection control risk.

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

At our last inspection the provider had failed to implement consistent practice with regard to obtaining and documenting consent for care and support. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements had been made at this inspection and the provider was no longer in breach of regulation 11.

● At our last inspection we identified restrictions had been placed on people, which infringed on their human rights. For example, restricting people's access to go out. At this inspection, people told us they were able to go out when they chose to.
● Best interest meetings and capacity assessments had not been completed previously, when people were deemed to lack capacity. At this inspection we saw evidence that best interest meetings and capacity assessments were in place.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved 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.

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.

● Since our last inspection we observed some improvements in relation to the volume and severity of incidents that had occurred at the service, however further improvements were still needed in a number of areas.
● Care plans had been reviewed since our last inspection but did not always provide the level of detail needed to mitigate risks to people. Care plans and risk assessments were not always reviewed and updated following incidents.
● The provider was in the process of implementing an electronic care planning system which the manager and staff felt would improve the quality of information required. However, the transition to the electronic care plan systems was not complete, with some people's care plans and risk assessments being on both the electronic system and in paper format. This could cause confusion to staff including agency and new staff and important information about risks to people not being shared. The manager had requested support from the provider, and extra resources were made available to transfer the documentation within two weeks of our inspection. We will check this when we next inspect.
● Medicines audits had failed to identify the issues we found on this inspection. Furthermore, the providers medicine administration policy was not specific to this location. We discussed this with the operations manager who assured us this would be updated to reflect processes and policies locally.

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 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

At our last inspection the provider had failed to notify the CQC of safeguarding incidents. This was a breach of regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

● Since our last inspection the manager had ensured notifications had been submitted to the Care Quality Commission, (CQC)as required. Services that provide health and social care to people are required to inform the CQC, of important events that happen in the service. CQC check that appropriate action had been taken.
● Since our last inspection the manager had reviewed restrictions placed on people and made amendments. The manager and staff had completed best interest meetings for people who lacked capacity in line with legislation.
● It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating in the reception of the service and on their website.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● At our last inspection, we found a closed culture which impacted negatively on people. At this inspection, we found some improvements, but further improvements were necessary. For example, some documentation reviewed was not always respectful, and one staff member we spoke with was not respectful about people. We discussed this with the manager who confirmed they would follow up with staff.
● Staff told us the culture was improving, one staff member told us, "I first joined here in 2019, if I compare staff morale then and staff morale over recent months, there's a marked improvement."
● The manager informed us they had worked hard to increase the morale with people and staff. We observed people to be relaxed and content. Staff were able to share with us positive outcomes for people, for example one person being more engaged in activities and with other people at the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Since our last inspection the manager had sought support and advice from external healthcare professionals. One professional had raised concerns about the quality of information staff shared with them. The manager investigated this and concluded that information had not been correctly implemented in the new system. The manager held a meeting with staff to confirm how and where to document this information. We will check this when we next inspect.
● At our last inspection people were not always involved in the service. At this inspection, there were improvements. People had asked to watch sporting events on a big television, so a projector and special meal was organised for those who wanted to be involved.
● A staff member told us, "Anybody can bring a suggestion any time they wish. Team leaders will hold residents' meetings where ideas are discussed and brought forward." Another staff member told us feedback was welcomed, "I think so. It's actively encouraged."

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
Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess the risks to the health and safety of people, doing all that is reasonably practicable to mitigate risks.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to protect people from abuse and improper treatment.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance 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.