Chimnies Limited

Chimnies Residential Care Home

Inspection report

Chimnies
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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Chimnies Residential Care Home is a residential care home providing personal care to 25 people aged 65 and over at the time of the inspection. Two people were cared for in bed. The service can support up to 29 people.

People's experience of using this service and what we found
People told us they felt safe and well cared for. Comments included, "I feel safe"; "I know most of the people here. We all mix together and have a laugh"; "They are a good bunch of people"; "The staff are quite nice"; "The carers are lovely people. They are very gentle and talk to me" and "The staff are very nice."

Relatives told us they were happy with the care at Chimnies Residential Care Home. Comments included, "They are brilliant. They've taken a whole lot of worry off us as we know he's being looked after"; "Mum is very happy there. They are a caring team"; "The care is exceptional"; "The staff go above and beyond"; "We know the individual carers quite well and they're all friendly"; "Chimnies is really good. I can't fault it. They are all very obliging and very friendly"; "It's like a big family. Staff are all very relaxed. You're not made to feel an inconvenience when you're there" and "It's little things like that make me feel they care."

Although people and relatives were happy with the care and support we found serious concerns about people's safety. Risks to people's safety had not been well managed. A range of risks to people had not been properly assessed or managed. Personal emergency evacuation plans (PEEPS) were not sufficient to enable staff to know which equipment to use and what action they should take to evacuate each person in the event of an emergency such as a fire. Fire risks were not well managed, we reported this to the fire service.

The staffing rota showed there were not enough staff on shift to safely meet people's needs. Medicines were not well managed. Protocols were not in place to detail how people communicated pain or constipation, why they needed as and when required medicines and what the maximum dosages were. Records and stocks of medicines were not safely managed.

The provider did not have effective safeguarding systems in place to protect people from the risk of abuse. Safeguarding concerns had not always been reported to the local authority. The registered manager lacked awareness of what action they should take in response to allegations of abuse.

We were not assured that the provider was admitting people safely to the service. People had moved into the service and had not been isolated in their rooms for the required period to meet government guidance in order to prevent the risk of spread of COVID-19 and to keep other people safe. PPE was not consistently used appropriately. This put people at risk. The provider was accessing testing for people using the service and staff.

Staff training and induction was not adequate to provide staff with the guidance and skills to safely carry out

their roles. Some people lived with diabetes, no staff had undertaken diabetes training. People also lived with Parkinson's and epilepsy, again no training had been provided to staff.

There was insufficient oversight of the service by the provider and registered managers to pick up and address the risks found by inspectors. Records were an area of concern across the service; records were not complete and accurate. The provider had failed to make improvements and the service had declined in quality. The provider and registered manager had not developed an open and honest culture where staff were empowered to raise any safeguarding concerns.

Assessments were not robust or complete. Assessments had not been reviewed and amended when people's needs changed. People were not assessed to check their capacity to make particular decisions when this was in doubt. Records were not kept to show how decisions were made in people's best interest. At this inspection, some capacity assessments were in place, these were not decision specific and showed a lack of understanding about the Mental Capacity Act 2005. 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; however, the policies and systems in the service did not support this practice.

People and relatives told us the food was good and met their needs. Mealtimes continued to be a social occasion where most people ate at dining room tables and had the opportunity to chat together. Most people's weights were regularly monitored to make sure they remained as healthy as possible.

People were supported to access healthcare services when they needed them. Relatives told us their loved one's health needs were met.

The environment required improvements. There was no signage to support people living with dementia (as well as new people to the service) to orientate themselves.

Staff were recruited safely. Disclosure and Barring Service (DBS) criminal record checks were completed as well as reference checks.

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 31 March 2020). Three breaches of regulations were found in relation to need for consent, person-centred care and good governance. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

Why we inspected
We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This inspection was also prompted by our data insight that assesses potential risks at services, concerns in relation to aspects of care provision and previous ratings.

The inspection was also prompted in part due to concerns received about people's safety and staffing levels. A decision was made for us to inspect and examine those risks. We undertook a focused inspection to review all the key questions review the key questions of Safe, Effective and Well-led only. This enabled us to review the previous ratings.

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 have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this report. Please see the Safe, Effective and Well-led sections of this full report.

The overall rating for the service has changed from Requires Improvement to Inadequate. 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 Chimnies Residential Care Home 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 monitor the service/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 risk management, medicines management, infection control, deployment of staff, safeguarding people from abuse, capacity and consent, staff training, records and effective systems to monitor and improve the service 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 continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner. 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.

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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Chimnies Residential Care 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 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 inspectors. An Expert by Experience spoke with people and 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
Chimnies Residential Care Home 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 had a manager registered with the Care Quality Commission. 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.

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 who commission the service. We also sought feedback from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. Healthwatch told us they had not visited the service or received any comments or concerns since the last inspection. A local authority commissioner told us they had visited the service and gave us feedback about this visit.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with 10 people who used the service about their experience of the care provided. We observed staff interactions with people and observed care and support in communal areas. We spoke with six members of staff including a cook, care staff, senior care staff and the registered manager.

We reviewed a range of records. This included five people's care records and multiple medicines 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. We spoke with a further three staff members.

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.

At the last inspection, the provider had failed to ensure records were accurate and up to date. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the breach of Reg 17 had not been met in other domains (Effective and Well-led). Registered persons were no longer in breach of regulation 17 in Safe as the areas of concern no longer focused on records, the areas of concern were based on risks to people's safety.

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

- At the last inspection, individual risks were not always identified and recorded. Care plans identified clear risks, however, a risk assessment had not been completed to support people's safety. At this inspection, risks to people's safety had not been well managed. Risk assessments were not in place in relation to building related risks which had the potential to cause serious harm. Hoists and chargers were plugged in and charging in protected stair wells which increased fire risks as well as reducing the width of the corridor which was a fire escape route. Fire doors were propped open with items which meant that people would be at risk if a fire started. We reported the fire risks to the fire service. The registered manager arranged for a fire assessment to take place and ordered fire door closure devices. The fire service visited the service within 24 hours and instructed the registered manager to take action.
- Additional building related risks were found in relation to potential exposure to hot pipes, and steep stairs to the attic space were not closed off to prevent unauthorised use despite the registered manager reporting to us a person was known to walk with purpose around the service.
- At the last inspection, people's needs had changed, and this had not always been captured in a risk assessment to prevent harm. At this inspection, risk assessments regarding people's care and support needs were not complete or robust. Some risk assessments gave conflicting information. There was no risk assessment in place to detail how staff should provide care and support safely to a person who was diagnosed with epilepsy.
- Risk assessments had not been created for people who had been admitted to the service. One person had been admitted to the service 12 days before the inspection. Staff had no details of how to provide safe care and what the risks were. When we asked staff about their care and support needs, they told us they were not sure.
- Choking risks had not been appropriately addressed. We observed one person lying flat in bed eating their meal independently. Their nutrition and hydration care plan did not provide guidance to staff to ensure the person was sat up and there was no risk assessment was in place in relation to the risks of choking. This put the person at risk of harm. We reported this to the registered manager who agreed to review this urgently to ensure the person was safe.
- One person's care record evidenced they had been on a pureed diet. Their GP had been contacted by the

service in October 2021 and it was recorded that the GP wanted the person to remain on a pureed diet. At lunch time we observed that the person ate food that did not match their care plan and the GP advice. They ate a roast dinner which was cut up. The kitchen staff told us no one had a pureed diet. They told us the person had their meal cut up really small. There was no evidence that a speech and language referral had been made to assess the person's swallowing and eating abilities. The registered manager confirmed that this had not taken place. This meant that the person was at risk of harm. The registered manager agreed to review this practice urgently.

● Personal emergency evacuation plans (PEEPS) were not sufficient to enable staff to know which equipment to use and what action they should take to evacuate each person in the event of an emergency such as a fire. Two people living at the service did not have PEEPs in place at all.

The provider and registered manager had failed to protect people from risks related to fire and the environment. Individual risks such as those related to health conditions and choking had not been assessed and care had not been planned to keep people safe. This placed people at risk. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the last inspection, the registered manager had not explored themes relating to accidents and incidents to enable the staff and service to learn lessons and review practice where required. At this inspection, accidents and incidents had been recorded by staff. The registered manager checked and recorded the number of incidents each month, including the number of falls in total, themes were explored, and any action taken was recorded.

Staffing and recruitment

● Before we inspected, we received a concern about unsafe staffing levels. At the inspection, we were not assured there were enough staff to meet people's needs. The staffing rota showed there were not enough staff on shift at night to safely meet people's needs.

● When we arrived at the service there were only three care staff on shift providing care to 25 people, some people required two staff to support them. Extra staff were drafted in during the inspection to provide care. The provider had a dependency tool in place to assess people's care and support needs. The registered manager did not use the dependency tool to inform the staffing rota to match people's needs to how many staff were required. Staff did not have time to carry out activities with people.

The provider had failed to deploy staff sufficiently. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

● Staff were recruited safely. Disclosure and Barring Service (DBS) criminal record checks were completed as well as reference checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

● Despite the staffing levels, people and relatives told us, "I just press a buzzer and they come running"; "There's definitely enough staff" and "I think there's enough staff to care. I've never identified any lack of care."

Using medicines safely

● Medicines were not well managed. The medicines room was not always secure. The service had policies and processes for managing medicines (including ordering, storing, administering and disposing of medicines). However, these were not always followed. For example, our checks identified discrepancies in quantities of prescribed medicines against records. Doses of medicines such as paracetamol had not always

been recorded when they had been administered. For example, some people were prescribed one or two paracetamol and it was not clear whether they had taken one or two.
● Protocols were not in place to detail how people communicated pain or constipation, why they needed as and when required medicines (PRN) and what the maximum dosages were. Staff (including those administering these medicines) may not have all the information they need about people's PRN medicines.
● A number of people had allergies recorded in their care plans which showed they were allergic to certain medicines. Their medicines administration records (MAR) did not record these allergies.
● We observed that medicines were given too close together which meant people would have to go longer between pain relief between their evening dose and their morning dose. Medicines due at 18:00pm were given at 16:30pm. Staff administering the medicines signed each MAR to show they had given the medicines at 18:00, they had not recorded that the medicines had been administered early. Staff told us they always completed the 18:00pm medicines round at 16:30. Staff told us this was to make sure the medicines due at night could be given early by day staff before going off shift as there was no one medicines trained to provide medicines support on a night shift. The registered manager told us after the inspection that the pharmacy had since been involved in reviewing medicines times to ensure gaps between medicines were suitable. The registered manager also told us they had arranged for a pharmacist to visit and carry out a full medicines audit of the service on 15 December 2021.
● Care plans were not always updated with current information about people's prescribed medicines. This meant inaccurate information could be given to healthcare professionals involved in the care of the person.

This demonstrates a breach of Regulation 12 (Safe Care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Senior staff including the registered manager had received medicines training and were assessed to ensure they were competent in the safe administration of medicines.

Systems and processes to safeguard people from the risk of abuse
● The provider did not have effective safeguarding systems in place to protect people from the risk of abuse. Safeguarding concerns had not always been reported to the local authority. One person had reported to the registered manager that a staff member had been very rough with them when supporting with personal care. The registered manager had not reported this to the local authority following the local authorities safeguarding protocols, policy and procedures.
● The registered manager lacked awareness of what action they should take in response to allegations of abuse, such as physical abuse and financial abuse

The failure to protect people from abuse and improper treatment was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite the findings above, people and relatives told us they and their loved ones received safe care. Comments included, "They are brilliant. They've taken a whole lot of worry off us as we know he's being looked after"; I'm very happy with it (the care)"; "My experiences with all care staff are very happy" and "Mum is safe and well there, she's very settled. If anything, she's better and happier. It's a weight off my mind."
● Most staff confirmed they had received safeguarding training and knew to report concerns to the registered manager. Staff were aware of the whistle-blowing process and who to contact if they had concerns about people's care or safety.

Preventing and controlling infection

● We were not assured that the provider was admitting people safely to the service. People had moved into the service and had not been isolated in their rooms for the required period to meet government guidance in order to prevent the risk of spread of COVID-19 and to keep other people safe.
● We were somewhat assured that the provider was using PPE effectively and safely. We observed that staff mostly wore their PPE correctly, however there were times when staff were sat in the same room as people with masks pulled down under their chins. This put people at risk.

This demonstrates a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● 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 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.

Requires Improvement

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. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

At the last inspection we the provider had failed to ensure assessment records were accurate and up to date. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At this inspection, assessments were not robust or complete. Assessments had not been reviewed and amended when people's needs changed. One person had been assessed at low risk of falls and the registered manager had recorded they had not had any falls since being at the service. However, their records showed they had fallen a number of times after their admission. Their falls risk assessment had not been reviewed, which meant staff were given the wrong information about risks associated with the person's care. No other professionals had been involved following the person's falls, a referral to the falls clinic had not been made.
● At the last inspection, people's care plans had been developed when they moved in, following their initial assessment, for instance 2016 or 2017 and had not been updated since. At this inspection, we found that two people who had lived at the service for five days and 12 days did not have any care plans in place and full and thorough assessments has not taken place.
● The registered manager showed us records of respite placements that had taken place at the service in recent weeks and months. We asked to see care plans and assessments in relation to this to ensure staff had been provided with all the information thy needed to provide safe care. The registered manager told us there were no care plans and assessments for these people as they had been short stays.
● Some people had bed rails in place on their beds to prevent them from falling and injuring themselves. There were consent forms and information to show how the person and their relative (if this was appropriate) had been involved in the decision making. However, a formal assessment had not been carried out to check what type of bed rail was suitable for the person and the bed following Health and Safety Executive guidance. This put people at risk of injury and entrapment. The registered manager agreed to address this.

The failure to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and to ensure accurate and up to date records are kept is a continued breach of Regulation 17 (Good Governance) 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.

At the last inspection, the provider had failed to ensure people's rights are maintained following the principles of the MCA is breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 11.

● At the last inspection, people were not assessed to check their capacity to make particular decisions when this was in doubt. Records were not kept to show how decisions were made in people's best interest. At this inspection, some capacity assessments were in place, these were not decision specific and it was not clear as to why they had been carried out.
● At the last inspection, the registered manager had only undertaken basic level training and did not have a good grasp of how to put the principles of the MCA into practice to maintain people's rights. Such as how to make an initial judgement about people's capacity to make particular decisions and how to assess and support a judgement. At this inspection, one person's mental capacity assessment which had been carried out by the registered manager stated, 'I believe [person] does lack mental capacity.' The assessment did not follow the mental capacity act code of practice and demonstrated a lack of understanding about the act.

The failure to ensure people's rights are maintained following the principles of the MCA is a continued breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager had correctly applied for DoLS within the MCA for some people living at the service. Some of these applications had been authorised by the local authority at the time of this inspection. The registered manager monitored when they were authorised or due for renewal. People's care plans detailed if they had a DoLS in place.
● Where people had a relative listed as their lasting power of attorney (LPA), copies of the LPA documentation had been checked by the registered manager to verify that relatives had the authorisation to make decisions on behalf of the person.
● Most people and relatives told us they made their own choices and decisions about their care.

Staff support: induction, training, skills and experience
● Staff training and induction was not adequate to provide staff with the guidance and skills to safely carry out their roles. Staff told us all training was completed online and this included moving and handling. Staff

were not assessed, or competency checked to ensure they were skilled and safe to use moving and handling equipment. One staff member had been employed for four months and had not completed any training at all until the end of their 3rd month.

● Some people lived with diabetes, no staff had undertaken diabetes training. People also lived with Parkinson's and epilepsy, again no training had been provided to staff.

● Training records did not evidence that staff had undertaken training in relation to skin integrity and pressure area care. We discussed this with the registered manager, they stated that pressure area care training had been provided, but had not been recorded.

The failure to ensure staff had the appropriate training to ensure people's needs were met is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

● People and relatives told us the food was good at met their needs. Comments included, "The meals are tasty and we get a choice", "The food is always edible"; "They bring my meals in to me and help me if I need it"; "Mum enjoys the food. She gets Sunday dinner and sherry" and "The meals are old fashioned, but mum loves that sort of meal."

● Mealtimes continued to be a social occasion where most people ate at dining room tables and had the opportunity to chat together. Staff advised people during the morning what the lunch choices were and asked what they would like to have. However, people we spoke with had not remembered what food options were available to them. There was no menu board on display to remind people (including those living with dementia) of the food choices. This is an area for improvement.

● We observed people were encouraged to stay hydrated throughout the day, people had jugs of cold drinks in their bedrooms and were offered hot drinks too.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● Most people's weights were regularly monitored to make sure they remained as healthy as possible. However, people who were unable to be weighed due to poor health and increased frailty had not been monitored. The provider and registered manager had failed to follow Malnutrition Universal Screening Tool (MUST) guidance in relation to people who people who cannot be weighed or have their height measured. MUST provides guidance to obtain, a likely body mass index range using the mid upper arm circumference (MUAC). We spoke with the registered manager about this and they were unaware of this guidance. They agreed to put in place effective monitoring to ensure each person remained healthy.

● People were supported to access healthcare services when they needed them. For instance, people regularly saw a GP, chiropodists and district nurses. People attended appointments with their healthcare specialists and consultants when required. We observed staff taking action to seek medical advice during the inspection when a person was unwell.

● Relatives told us their loved one's health needs were met. Comments included, "Since admission I can see 100% improvement in [person's] physical and mental health. [Person] has now gained weight, not having so many falls, [person] is being well cared for and most of all he has company"; "They immediately ring to tell me if he's had a fall and notify me after the doctor has been" and "Since being in Chimnies, mum's health has improved. They've levelled her drugs out and she has lost some excess weight."

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

● At the last inspection, the building, although in need of updating, met the needs of the people living in the service. The registered manager recognised the building design and furnishings did not meet the needs of people living with dementia. Although this was not a concern at the time, they were planning new initiatives

to improve the environment for people living with dementia. At this inspection, improvements had not been made to the environment. There was no signage to support people living with dementia (as well as new people to the service) to orientate themselves. This is an area for improvement.

● Most people had access to countryside views from their bedroom windows. People could access the gardens easily as well as a field with ponies and donkeys. Since the last inspection a summer house had been built in the garden to enable people and their relatives to meet safely.

Relatives told us, "They've put a cabin in the grounds. To us it's brilliant because we can see [person] without masks on and we feel safe"; "Used the cabin to visit mum and I thought the speaker system in there was really good" and "They've gone above and beyond to build a cabin during COVID-19 so that we were allowed to visit."

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At the last inspection the provider and registered manager had failed to keep up to date with current and best practice and to ensure good governance and quality monitoring systems were effective and accurate is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection no improvement had been made and the provider was still in breach of regulation 17.

● At the last inspection, the provider had a monitoring system in place to check the quality and safety of the service; which was not used effectively. There was a lack of understanding by the provider and registered managers about the reasons why they carried out audits. At this inspection, this remained the same.
● At the last inspection, we found many concerns with people's care plans and how records were kept up to date during the inspection. At this inspection, this remained the same. Records were of poor quality or did not exist.
● At the last inspection, medicines audits did not include random checks of medicines in stock. Although staff counted medicines once administered, the registered managers did not have a process to check this was working effectively and assure themselves of safety. At this inspection, this remained the same.
● The systems in place to audit the quality of the service were not robust or sufficient to alert the provider or registered manager of concerns and issues within the service. Audits had not picked up significant shortfalls in practices in relation to risk assessment, fire safety, infection control, medicines management, staff deployment, meeting people's needs, training, capacity and consent, care planning and records.
● People were at risk because the provider had not acted to ensure they had enough oversight of the service. There had been a lack of provider and management oversight at the service which had caused issues with safe staffing levels, monitoring of practice and day to day management.
● The provider had failed to improve the service since the last inspection which meant the service had declined further in quality.

The provider had failed to operate a robust quality assurance process to continually understand the quality of the service and ensure any shortfalls were addressed. The provider had not maintained accurate and complete records in relation to the service and people's care. This placed people at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

● Registered persons are required to notify the Care Quality Commission (CQC) about events and incidents such as abuse, serious injuries and deaths. The provider and registered manager understood their role and responsibilities, had notified CQC about all important events that had occurred. However, they had not fully met their regulatory requirements because an incident of abuse had not been reported to CQC when it had occurred.

The failure to notify CQC in a timely manner about incidents that had occurred is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Continuous learning and improving care; Working in partnership with others

At the last inspection, the provider and registered managers had not kept up to date with changes in social care. They had not taken opportunities to update their skills and knowledge to benefit the experience of people using the service. The provider and registered managers did not attend any local or national events or forums to make sure the practices they were following were current and best practice. They were not signed up to well known, reputable websites to find advice and guidance. They relied on being advised how to move forward by visiting professionals such as local authority officers. This had a detrimental effect on the quality of service provision. We made a recommendation about this.

● At this inspection this remained the same. The provider and the registered manager had not been keeping up to date with local and national developments within health and social care and they had not taken opportunities to update their skills and knowledge to benefit the experience of people using the service.
● The provider and registered managers had not attended any local or national events or forums to make sure the practices they were following were current and best practice. They were not signed up to well known, reputable websites to find advice and guidance such as Skills for Care. Skills for Care supports adult social care employers to deliver what the people they support need and what commissioners and regulators expect.
● The provider and registered manager had not attended any provider or registered manager forums hosted by the local authority.

The provider had failed to update and improve their practice to ensure they operate a robust quality assurance process to continually understand the quality of the service and ensure any shortfalls were addressed. This placed people at risk of harm. 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
● The culture of the service had deteriorated since we last inspected. The registered manager had not instilled an open culture where staff felt confident to report any whistleblowing concerns to the registered manager or provider. Staff reported to us that the identity of whistle blowers to CQC prior to the inspection had been investigated in the service rather than an open and transparent investigation into the issues raised. This could make staff wary of reporting concerns for fear of reprisals. Allegations raised by the anonymous whistle blower about staffing levels were found to be accurate at this inspection.
● Despite the evidence found during the inspection, people and relatives told us they were very happy with the care at the service. Some relatives gave examples of the service achieving good outcomes for their loved ones. Comments included, "Since admission I can see 100% improvement in his physical and mental health.

He's now gained weight, not having so many falls, he is being well cared for and most of all he has company"; "He even goes out for walks in the garden and sees the animals which he loves"; "My mum has got better during COVID-19, it's brought her out of herself quite a lot" and "Mum is socializing more now than she ever did before."

● We observed that people knew the registered manager. Some people actively sought the registered manager out in their office to chat.

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 and registered managers understood their responsibilities under the duty of candour when incidents occurred. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. The registered manager kept families informed of any concerns and incidents within the service or with their loved one.

● Relatives confirmed this. Comments included, "I know [registered manager] would ring us if there was any problems at all"; "If I had any problems, I would speak to the manager on the phone"; "If anything happens they phone me straight away"; "I'm kept informed. I never feel cut off or in the dark" and "Chimnies always answer the phone. The manager will always chat to you if she's there and she will always ring back if she's not."

● 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. The provider had displayed a copy of their rating in the service.

● The service had received compliments from relatives. One read, 'Although nan only had a very short stay with you, thank you all so much for looking after her over this past month.' Another read, 'Thank you for all you do for [person].' Another read, 'Everyone showed him love, care and understanding which was so important to us as a family during a difficult time. He spoke well of everyone but particularly [staff member] who he seemed to take a real shine to especially during his isolation period where she showed real kindness.'

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People had various ways to raise concerns or ideas for improvement. Residents meetings were held every month with good attendance. The notes from the meetings showed discussions where people were listened to and action was taken. People were enabled to provide their feedback in a group or individually.

● Relatives told us they had not been sent surveys to gain their feedback. Comments included, "I don't get questionnaires" and "I've never had any calls or questionnaires to ask me how things are going."

● The registered manager told us they held regular staff meetings to keep staff up to date and to ensure staff were aware of their expectations. Records confirmed this. However, some staff told us that meetings did not happen regularly. We discussed this with the registered manager, they told us, "Meetings happen daily and I do not always formally call them meetings." The registered manager told us they would improve communication to help staff recognise when they were having a meeting.

● As well as face to face communication through handover sessions, communication was also completed through written messages via a senior communication book and instruction book.

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 18 Registration Regulations 2009 Notifications of other incidents The failure to notify CQC in a timely manner about incidents that had occurred is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Registered persons had failed to ensure people's rights are maintained following the principles of the MCA. This is a continued breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We imposed conditions on the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider and registered manager had failed to protect people from risks related to fire and the environment. Individual risks such as those related to health conditions and choking had not been assessed and care had not been planned to keep people safe. This placed people at risk. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to manage medicines effectively. This was a breach of Regulation 12 (Safe Care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to admit people safely to the service. People had moved into the service and had not been isolated in their rooms for the required period to meet government guidance in order to prevent the risk of spread of COVID-19 and failed to ensure staff wore appropriate PPE at all times. This demonstrates a breach of

	Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We imposed conditions on the provider's registration

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 Registered persons had failed to protect people from abuse and improper treatment was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We imposed conditions on the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and registered manager had failed to update and improve their practice to ensure they operate a robust quality assurance process to continually understand the quality of the service and ensure any shortfalls were addressed. The provider and registered manager had failed to ensure accurate and up to date records are kept. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We imposed conditions on the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Registered persons had failed to deploy staff sufficiently and had failed to ensure staff had the appropriate training to ensure that people's need were met is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

The enforcement action we took:

We imposed conditions on the provider's registration