B & M Investments Limited

Chesham Bois Manor

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Chesham Bois Manor is a residential care home providing personal care to 44 people aged 65 and over at the time of the inspection. The service can support up to 48 people.

Chesham Bois Manor accommodates people across three units, with two of the units providing care to people living with dementia. The service has a mix of bedrooms with en-suite facilities and other bedrooms where people access the communal bath/ shower facilities. Each unit has it's own communal lounge and dining area. The service is set in well-maintained grounds with a secure outside area for people to access.

People's experience of using this service and what we found
People and the majority of relatives were happy with the care provided. However, we found safe and effective care was not consistently provided.

Risks to people were not mitigated and people were not safeguarded from abuse. There was no evidence of learning from incidents to prevent reoccurrence and promote safe care. Medicines were given as prescribed however, discrepancies in medicines were not identified and protocols were not in place for other medicines.

Staff were not suitably recruited, inducted, trained and supervised. Sufficient staff were not maintained to ensure people got the care they required. The impact of the staffing levels meant people's care was rushed and/or omitted.

People were happy with the meals provided. However, we found people were not supported with their meals in a timely manner and their nutrition and hydration needs were not met.

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

The service was not effectively managed and monitored to ensure safe and effective care was provided. Records were not accurate, always dated, secure and fit for purpose.

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

Rating at last inspection
The last rating for this service was good (published 26 July 2018). The service had an infection control inspection in January 2021 (published 8 February 2021), which did not result in a review of the rating and the overall rating remained unchanged at that time.

Why we inspected
The inspection was prompted in part by concerns raised about people's nutrition, hydration and personal care needs not been met. This inspection examined those risks.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well- led sections of this full report. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good 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 Chesham Bois Manor on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safeguarding people, management of risks, medicine practices, recruitment, induction and training of staff, staffing levels, record management, auditing of the service and failing to work to the principles of the Mental Capacity Act 2005.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Chesham Bois Manor

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 one inspector over three days. A specialist advisor who was a dietician assisted the inspection on day one and an Expert by Experience assisted the inspection on day two.

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
Chesham Bois Manor 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, with notice given by telephone from outside the property on day one and day three of the inspection.

What we did before the inspection

We reviewed information we had received about the service since the last inspection, which included notifications made to us. We sought feedback from the local authority commissioners who work with the service. The provider was in the process of completing their Provider Information Return at the time of the 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. The timescale for the return of the completed form was after the inspection and therefore, not used to plan the inspection.

During the inspection
We spoke with seven people who used the service and three relatives about their experience of the care provided. We spoke with 14 staff including the registered manager, operations manager, head of governance, director of organisational culture, head of training, deputy manager, team leaders, senior carers, carers, administration staff, cook and a member of the housekeeping team. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records relating to people's care which included, multiple medicine records, seven care plans and daily monitoring records. We reviewed five staff recruitment files, staff rotas and training records.

A variety of records relating to the management of the service, including health and safety, accident/incident reporting, complaints, policies and procedures were reviewed, and others requested.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at policies, seven electronic care plans, meeting minutes, training data and quality assurance records. We contacted relatives and received written feedback from seven relatives.

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

Systems and processes to safeguard people from the risk of abuse

- People were not always safeguarded from potential abuse. In a person's daily records, we saw incidents of physical aggression towards others was not identified or reported as a safeguarding incident. Therefore, people were not safeguarded. The provider agreed to review the person's daily records and made safeguarding alerts in retrospect of the incidents noted.
- During the inspection we observed a person, with a known risk of malnutrition was not offered a meal or drink during lunchtime. Staff failed to notice to safeguard the person. This was addressed when pointed out to them and a safeguarding alert was raised in respect of the omission.
- The team meeting minutes dated 28 October 2021 showed discussions had taken place about failures to safeguard people. These included concerns about people's skin integrity, failure to reposition a person for 12 hours, practice of double padding people at night and poor staff moving and handling techniques. There was no indication these concerns had been referred to the local authority safeguarding team, investigated by the service or action taken to safeguard people. This was fedback to the provider to investigate. We await the outcome and subsequent actions.
- The provider had safeguarding policies and procedures in place and staff were trained in safeguarding. During discussion with staff they indicated they were aware of their responsibilities to report poor practice and potential safeguarding incidents. However, staff practice, incomplete records, failure to recongnsie safeguarding incidents, staffing levels and the culture within the service did not safeguard people.

People were not safeguarded from the risk of abuse. This 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.

- People told us they felt safe. People commented "I feel safe because of the company", and "Obviously there's always someone senior who is about. If you run into trouble. They come and see you straight away and ask what you need". Relatives felt confident their family member was safe and gave us examples where equipment such as sensor mats and specialist beds were provided to promote their family members safety.

Assessing risk, safety monitoring and management

- Risk management was not effective in mitigating risks. A person with epilepsy did not have a risk assessment to outline the seizure type and action to take in the event of a seizure. The registered manager and staff spoken with were unaware the person had epilepsy. Therefore, the risks associated with the epilepsy were not identified, mitigated and had the potential to put the person at risk in the event of a seizure.
- The service supported people with behaviours that challenged. The triggers for the distress were not

outlined and risks associated with the behaviours that challenged were not identified and mitigated. In records viewed we saw incidences of physical abuse towards people and staff were not reported and acted on to ensure the person could be safely supported to mitigate risks to them, other people and staff.
● Staff were not observant of potential risks to people. Throughout the inspection we observed a wet floor and people wearing slippers that were too big, open heel and/or loose. One person was supported to mobilise with their frame and their slipper was undone. This went unnoticed by the staff member supporting the person, until it was pointed out to them and did not mitigate the risk of falls to the person.
● Risks around skin integrity were identified, however records showed people were not repositioned at the frequency required to mitigate the risks to them. For example, a person's Pressure Area Risk Assessment Chart (Waterlow) completed on the 5 November 2021 showed that their risk of pressure area damage went from high to very high. The turning chart from the 9 November 2021 showed many occasions where the person was not repositioned two hourly as outlined in their plan of care. On one occasion, there was a gap of seven hours and 49 minutes and the daily records for that date did not indicate the person was repositioned during this time either. The provider was made aware of our findings to mitigate the risks to the person and we requested that they made a safeguarding referral to further safeguard the person.
● We observed a cleaning trolley left unattended in the corridor by the office. Cleaning products were accessible on top and a smoothie drink was left on the second shelf of the trolley. This had the potential to put people at risk of ingesting cleaning products. The cleaning trolley was lifted down two steps to the cleaning cupboard which posed risks to the staff member. The staff member told us that is how the trolleys are taken to and from units. The risks around this practice had not been considered.

Safe care and treatment was not always provided. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service had an environmental risk assessment which outlined risks within the service, that was due for review on the week of the inspection. People had Personal Emergency Evacuation plans (PEEP's) in place which outlined how people were to be evacuated in the event of a fire.
● Equipment such as the gas, electric and fire equipment was serviced. The most recent fire drill had taken place in August 2021. During the inspection the fire alarm was activated. However, staff did not follow the procedure in that a staff representative from each unit did not come to the panel to establish if it was a fire. The provider representative reassured us on day three of the inspection fire drills and training of staff would be scheduled to address the poor response to the false fire alarm the week before.

Using medicines safely
● Systems were in place to ensure safe medicine practices. However, the controlled drugs register was not an accurate record for medicines returned to the pharmacy. This meant the provider had not assured themselves that those medicines were safely disposed of, in line with the providers medicine policy and best practice guidance on handling of controlled medicines in care homes.
● The service supported people for whom "as required" (PRN) medicines were prescribed. The provider's medicine policy stated that when as required (PRN) medication is prescribed, it is essential that clear instructions are received from the GP or authorised person describing the circumstances in which PRN medication should be given (i.e. signs, symptoms, behaviours), the amount to be given, and how often the dose may be repeated in 24 hours. In two people's medicine administration records viewed guidance was not provided for when PRN Lorazepam and Diazepam was to be administered.
● A person's care plan indicated they had homely remedies in their bedroom. It did not outline what those medicines were and the risks around this had been identified and mitigated. During discussion with the deputy manager they told us the person's relative had taken those medicines home as they were out of date. However, they had not considered the risks around the practice in line with the providers medicine

policy or the need to update the care plan to reflect the change in planned care.

Safe medicine practices were not always promoted. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Systems were in place to record medicines received, administered and disposed of. Stock checks of medicines took place and temperature checks were maintained of the medicine cupboard, fridge and the room medicines were stored in. People's medicine administration records showed no gaps in administration. Topical medicine administration records were in use and showed where creams and ointments were to be applied and when administered. Some people were prescribed transdermal patches. This is a medicated adhesive patch that is placed on the skin to deliver a specific dose of medication through the skin and into the bloodstream. Transdermal patch records were in place which showed transdermal patches were rotated on application and administered at the frequency prescribed.

Learning lessons when things go wrong
● The service had systems in place to promote learning from accidents/incidents. The electronic monitoring system had the ability to pick up trends and reoccurrences. However, incidents were not logged which meant the provider was unaware of incidents of physical abuse of other people and staff. This meant action was not taken to prevent reoccurrence.
● The service had been subject to a local authority safeguarding investigation which focused on people's nutrition and hydration. This had resulted in learning for the service. However, during the inspection we observed concerns with people's nutrition and hydration intake and therefore was not assured that learning from the local authority investigation had been effective in preventing reoccurrence.
● The service had introduced monthly governance meetings to enable them to discuss changes in people and take action to address concerns. At the governance meeting dated 2 October 2021 they had identified a number of people had not been weighed at the frequency required. However, whilst this was noted there was no evidence of action to prevent reoccurrence, as in records viewed, we found people were not weighed as required.
● The staff meeting minutes dated October 2021 indicated complaints had been raised about people's care and skin integrity. These were not recorded as complaints and investigated to promote learning and prevent reoccurrence.

Systems were not established and effective to promote learning from incidents to prevent reoccurrence and promote safe care and treatment. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Sufficient numbers of staff were not provided on shift. The registered manager confirmed the staffing levels based on people's current dependency levels was eight staff on the daytime shifts which included team leaders and senior carers. Four staff were required on the night-time shift with included a deputy manager, team leader or senior carers. We saw the required staffing levels were not provided, which resulted in care being rushed and for other people the care and support they required was not provided in a timely manner or not at all. For example, at lunchtime there was a delay in people getting their meal, the required support and intervention to eat their meal.
● Staff told us the required staffing levels was routinely not provided and their annual leave had been cancelled which had impacted on staff morale. Staff commented "Rotas do not reflect skill mix which means shifts are badly managed". "Work is pressured, everything is rushed which impacts on people's care" and "We are regularly short staffed, care is rushed, and activities are limited".

● The rotas viewed from 25 October 2021 to 14 November 2021 showed 28 out of 42 daytime shifts and four night-time shifts where the required staffing levels was not provided. The registered manager completed a risk assessment when the required staffing levels were not provided. However, this was a statement around a shift being short staffed as opposed to mitigating the risks to people and staff as a result of sufficient staff not being available.
● The registered manager commented "The staffing levels were not ideal, but they were trying their best". However, the lack of oversight of the rota, care practices and the acceptance of shifts being short meant people were not adequately supported.

Sufficient numbers of staff were not provided. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection and took immediate action to source agency staff to mitigate risks to people.

● The home had a high turnover of staff over the year in that 21 staff had left but only 13 new staff had been recruited. The service was committed to recruiting into the staff vacancies but struggled due to the lack of applications for roles. The registered manager told us they had difficulties in obtaining agency staff to cover shifts or agency staff booked for shifts sometimes did not turn up. They had introduced a twilight shift to cover both shifts. They intended to change the shift pattern following consultation with staff as they believed it would provide more continuity of care for people. However, this would not be effective till the start of 2022.

● The provider had a recruitment policy in place which outlined the process for recruiting staff. However, this was not followed. The providers policy indicated references should be verified by phone. There was no evidence in the staff files viewed this had happened. We found references from previous employers were not always obtained or the reference provided did not relate to the employment history recorded on the application form. In one file viewed, only two-character references were on file which the applicant had indicated were related to them. However, this was not explored or verified, and a risk assessment was not on file to indicate risks around this had been considered and mitigated.
● The interview record prompted the interviewer to explore gaps in employment. This was noted but no detail was provided as to the reason for gaps in potential candidate's employment histories. The health questionnaire check was dated as completed, after the staff member commenced employment. This meant risks associated with medical conditions were not identified and mitigated. This was not in line with the providers policy which indicated a health questionnaire should be sent to a potential candidate prior to an offer of employment being made.

Recruitment procedures were not operated effectively to ensure fit and proper staff were employed. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection to address the gaps in recruitment files and commenced an audit of all staff files.

● Potential candidates attended for interview. A recent photo was on file and disclosure and barring service checks (DBS) were carried out on all new staff before they commenced work at the service.

Preventing and controlling infection

● We were somewhat assured that the provider was using PPE effectively and safely. The service had access to sufficient PPE. However, during the inspection a staff member wore their mask off their nose, whilst they were serving meals. Alongside this, staff who were serving meals went to assist a person to move up their bed with the food tabards on. They then came back into the dining room to continue serving the meals. The risk of cross infection had not been considered and mitigated.
● We were somewhat assured the provider was promoting safety through the layout and hygiene practices of the premises. The provider had systems in place to promote a hygienic environment. The home was generally clean. However. we saw the C\OVID -19 governance checks were not completed since July 2021 and the daily weekly infection control check was not completed since 11 August 2021. Alongside this, there was gaps in cleaning records and the service had not assured itself that high touch areas were cleaned at regular intervals during the day.
● 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 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 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.

It is recommended the provider works to best practice to prevent and control infections.

Inadequate

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 good. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

● People's care plans outlined their nutritional needs and risks. However, staff practice and people's records did not assure us that people's nutritional needs were met. We observed mealtimes over the course of the inspection. We found mealtimes on the dementia care unit was chaotic, noisy and not conducive to promoting an enjoyable, calm experience for people. The staff serving the meals were crashing and banging the utensils and serving trays. This created a high level of noise in the dining room, which resulted in staff not being aware of people's distress or requests. In another unit staff shouted people's meal choices through the hatch to the kitchen, without considering the impact of that for people.

● A person sat at a table with three other people did not get served their lunch at the same time as others at the table. They continuously asked where their meal was and why were they not getting a meal. None of the staff acknowledged them or provided a rationale for the delay with their meal. After 20 minutes we intervened to establish why the person had not been given a meal. This was then provided.

● Meals and drinks were placed in front of people without any engagement with them or a prompt to eat their lunch. Cups were placed on the table with the handle away from the person. A person was given a meal and they asked for the other option. The staff member failed to acknowledge their request and the person eventually ate what they were given. Another person asked for a cup of tea after their meal. They continually asked different staff members with each staff member asking them how they liked their tea. Each time this intervention led to the person becoming distressed. It took 25 minutes for the person to get a cup of tea.

● There was no oversight of mealtimes. We observed a person being supported with their pudding. Spoonful's of food was quickly put in their mouth, whilst their mouth was still full of food. The task was rushed, lacked engagement and had the potential to put the person at risk of choking. Another person was sat at the table with their meal in front of them from 12.25 pm till 1.10 pm None of the staff stopped to offer encouragement or support to eat their meal. At 1;10 pm they were supported by a staff member to eat the now cold meal. Another person was observed in their bedroom during the mealtime. Throughout the period of our observation from 12.35 om to 2.10 pm staff did not go into their bedroom to offer them a meal or drink. Their daily records reviewed after the observation showed the last interaction with the person was at 11;15 am that morning. The person's weight charts showed they had lost weight on the previous months weigh in. However, despite this staff failed to ensure they were offered a meal and drink to mitigate the risks to them.

● Some people choose to eat in their bedrooms. However, no staff member had responsibility for oversight of people eating in their bedrooms which posed risks to them. At 2.10 pm a person was sat in their bedroom with their meal untouched. This person's weight chart also showed they were steadily losing weight.

● People's malnutrition risk assessment outlined the frequency at which individuals were to be weighed. In

five care plans viewed we saw people were not weighed at the frequency outlined in the malnutrition risk assessment. This had the potential to increase the risks to them of malnutrition. A person's weight chart showed they were not weighed in October 2021 and they had lost 2.6 kilograms in weight from the 16 September 2021 to the 3 November 2021. Another person, on weekly weights was not weighed weekly. They were not weighed in September 2021 and had lost 4 kilograms in weight from August 2021 to October 2021. They had lost another 1.5 kilograms when weighed in November 2021 which further increased risks of malnutrition to them.

● Weight losses and concerns around food and fluid intake was discussed at the morning meeting and staff meeting to ensure senior staff on the units were aware of them. However, this was not effective in addressing the failures in meeting people's nutrition and hydration needs.

People's nutritional and hydration needs were not met. This was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were provided with a varied menu and provided with two meal choices. An alternative meal option was available if required by individuals. Specialist diets were catered for. Supplements and snacks were available to encourage people at risk of malnutrition to eat regularly. The provider was planning a workshop on nutrition for the catering staff to further support them in improving meals and nutrition to benefit people.

● People and their relatives were happy with the meals. They commented, "The food is excellent," and "The food is tasty… I like to go to the dining room. It's a nice atmosphere. I sit with friends at the same table and we chat together".

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.

●The provider had a policy in place which outlined their responsibilities in relation to supporting staff to work to the principles of the MCA. Staff had received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, discussions with staff including the registered manager and records viewed showed a lack of understanding of the MCA.

● Records showed decision specific MCA's were not completed for all aspects of care provided. For example, some people did not have a mental capacity assessment and record of a best interest decision for the frequent COVID -19 testing and recent flu vaccinations that had taken place.

● A person's mental capacity assessment showed the decision to be made was whether bed rails should be

used to promote their safety. The decision that was made was that it was in the person's best interest to have their medicines administered.
● Another person's records showed they had capacity to make decisions on their care. A series of mental capacity assessments were completed which confirmed the person had capacity. During discussion with the registered manager they commented "The MCA's were completed to prove the person had capacity and surely it was better to have done that, than not do them". One of the five principles of the MCA is that there is a presumption of capacity, unless you have reason to believe otherwise, which was not the case for this person.
● A relative told us the registered manager had made a decision to move their family member to another unit. The relative felt it was not in their family members best interest to be moved from a unit they were familiar with. However, they were not reassured that the registered manager was making the decision in the person's best interest and therefore raised it with us as a concern. We informed the provider to enable them to investigate the concerns and respond directly to the family member with the outcome of their investigation.

The service was not working to the principles of the Mental Capacity Act 2005. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● People were not supported by staff who were inducted, trained and supported in their roles. The service was in the process of transferring their training records to another system. However, they were unable to provide us with an overview of the training staff had or required. The training matrix provided showed gaps in training and training scheduled in October 2021 had been cancelled. The registered manager confirmed new staff completed inductions and staff with no experience of care worked through the care certificate training modules. However, induction and training records were not available or complete to evidence that.
● The service carried out competency checks on staff which included personal care competency checks. The completed personal care competency checks viewed were a tick list. Where improvements were identified, there was no detail on what needed to improve or how it would be addressed and monitored. The provider required staff involved in medicine administration to have their competencies to administer medicines reassessed every six months. The records showed six staff involved in medicine administration were overdue this assessment. The registered manager confirmed they were aware medicine competencies assessments were overdue for some staff and they confirmed they continued to allow those staff to administer medicines without a reassessment.
● We observed staff in senior roles were not working in line with their training and were not positive role models for junior staff. We saw poor infection control practices where the risk of cross infection was not mitigated and throughout the inspection the culture within the service did not promote people's dignity with a person being described as "kicking off", "challenging behaviours", use of terms of endearment and other people being ignored at mealtimes or when trying to get staff's attention.
● Staff felt the training provided was not sufficient. They told us face to face training had stopped over the previous year during the pandemic. Staff in senior roles told us they had no specific training for their role, and it was a case of learning on the job. Staff commented "Mainly on-line training provided, practical training has not been happening and as a result staff are not trained in the right way", and "I feel like I need more in-depth training, it needs to be more thorough and practical".
● The providers policy on supervision and appraisals outlined that staff would have six supervisions a year. The supervision matrix provided showed staff were not supervised in line with the providers policy. Some staff had no supervision recorded and others only had an annual appraisal recorded since January 2021. Staff told us they did not receive regular supervision and were not supported in their roles. Staff commented

"I cannot recall when I had a supervision, no I do not feel supported or listened too", and "Supervisions are not happening, and I don't always feel supported".

Staff were not suitably inducted, trained and supported in their roles. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider had a policy in place which outlined the process for assessing people prior to coming to live at the home. The assessment took account of people's cultural needs, preferences and religion. Training records showed some staff were trained in equality and diversity to support individuals.

Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support
● People had access to other health professionals such as GP services, chiropody and dentist. A GP visited the home weekly and reviewed people and the district nurse team had regular involvement with people.
● The registered manager confirmed they were able to access other health specialists when required, such as the Speech and Language therapist, dietician and mental health teams.
● People told us they had regular access to see the GP. They commented ""There is a GP comes every week. Anybody who has any queries puts their name on the list. The doctor will examine you and prescribe medicine if required".
● Relatives confirmed people's medical needs were met. Relative's commented "The GP who serves this home is extremely good. The GP will ring me in the evening if they have seen [Family member's name]", and "Health professional access to the care home is good i.e. local doctor, nurses, chiropodist etc and staff have kept me informed of any changes in my family members health and welfare."

Adapting service, design, decoration to meet people's needs
● Chesham Bois Manor was suitably maintained with a programme of refurbishment and redecoration underway.
● The dementia care units had sensory and visual displays on corridors and windows and signage was used throughout to orientate people to their surroundings.
● Handrails were in use in corridors and the service had a chair lift and a lift to other floors.
● The ground floor unit had an enclosed secure outside area that people could access, and the service had large well-maintained gardens.

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 good. 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- We received mixed feedback on the management of the service. Staff did not feel the service was well managed. Some staff did not find the registered manager accessible or approachable. Staff commented "[Registered manager's] name is very sarcastic and critical. They do not lead by example and I do not have confidence that they know what they are doing". and "[Registered manager's name] is firm and do not take any nonsense. Most of the time they are not approachable".
- During the inspection we observed the registered manager was slow to react to the emergency call bell and fire alarm. They had no oversight of staff practice, tasks and failed to see the seriousness of the concerns we found which has resulted in the overall rating of inadequate for the service.
- Staff told us they felt unsupported, undervalued and described the staff morale as low with poor communication and no teamwork. A staff member commented "Team building has taken place, but behaviours and attitudes haven't changed which does not make it a happy place to work".
- Some relatives did not feel the service was always managed effectively and they found the registered manager difficult to relate with. A relative commented "I have had to approach the manager a couple of times about things. However, I never feel comfortable doing so as I find I get a rude and abrupt response with no compassion for a family member," and "The manager does not instil you with faith and confidence. They have no compassion or care for anyone".

The service was not effectively managed to provide good outcomes for people. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People and the majority of relatives were generally happy with the management of the service, although some relatives felt there should be more management supervision of staff at the weekends and staff available to answer the door and telephone, as the reception area is not staffed at the weekends.

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

- Our findings from the safe and effective domain showed the service was not safely managed and appropriately audited to mitigate risks and meet regulatory requirements. The provider had systems in place to audit the service. This included person centred software which enabled them to have an overview of people's care. Alongside this a series of in-house audits took place which included audits of staff

recruitment files, medicines, falls, care plans, infection control and aspects of health and safety. However, this auditing failed to identify the shortfalls we found with medicine records, recruitment files, and infection control. The infection control audit completed in September 2021 showed no issues and failed to identify that cleaning schedules and COVID -19 record checks were not completed. There was no effective auditing of the rota which resulted, in poor management of the rota and the risks around insufficient staff on shift was not mitigated.

● The service had introduced a monthly governance meeting to review people's care and a daily morning meeting to promote communication on people's care. The minutes for the 2 October 2021 governance meeting showed issues were identified with people's weights not been completed at the frequency required. However, no action was taken as we found that since the date of the governance meeting people continued not to be weighed at the required frequency and the risks around those omissions of practice were not mitigated. The morning meeting record showed discussions on admissions, visitors, activities, as well as raising any concerns about the rotas, people's care and identifying who needed weighing, repositioning and were on fluid and nutrition watch. However, there was no monitoring and oversight of staff on shift to ensure that the tasks delegated were completed and people's needs were met.

● The October 2021 team meeting showed the registered manager was aware people were not been repositioned, weighed, personal care was not being carried out and staffing levels were not sufficient. However, no strategies were put in place to address and monitor the concerns, other than staff being reminded they needed to do better and work as a team.

● People's care records were not always contemporaneous, accurate or complete. Their repositioning, personal care and weight charts showed gaps in recording and were incomplete. Other records were not dated, and the training folder was in a state of disarray with information not easily accessible. Paper records were not always filed and accessible. The registered manager had various piles of paper around the office, but they were unable to access a specific record when they wanted to show us evidence of discussions, they indicated they had with staff around concerns we had identified.

● Cleaning schedules and some health and safety check records showed gaps in completion. The registered manager informed us the gaps in the health and safety checks had occurred due to the staff member responsible being away from the service. However, those tasks were not delegated to enable the provider to be assured that the equipment in the service was safe and in good working order. The rotas contained codes for shifts, with no key code provided to explain the codes. Agency staff were recorded as agency as opposed to their names being recorded to provide an accurate record of staff on shift.

Good governance was not established, and records were not suitably maintained. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The operations manager carried out monthly audits on behalf of the provider. The audit completed on the 30 October 2021 showed a total audit score of 67% which showed the service was failing. An improvement plan was in place to address the findings and the provider was supporting the registered manager to improve the service.

Continuous learning and improving care. Working in partnership with others

● There was systems in place to promote learning from incidents to improve care. However, our findings in the safe and effective domains showed improvements were not embedded into practice for these to be effective to improve care.

● The service worked closely with local health professionals. However, the registered manager was not proactive in taking up the offer of training from the Local Authority to support them in making improvements.

Continuous learning and working with others was not established to improve care for people. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Systems were in place to get feedback on the service annually, however annual surveys had not taken place in line with the providers policy on seeking feedback. Relatives were surveyed in August 2020 and residents were last surveyed in 2019. The provider agreed to complete those surveys without delay.
- Staff questionnaires were sent out annually, and a staff surgery was held with the human resources department in June 2021, which resulted in a 'you said, we did' poster.
- The meeting minutes showed staff meetings took place three monthly and resident meetings had taken place in April and July 2021.
- During the pandemic relatives were updated by email on guidance relating to COVID -19, visiting and were enabled to keep in touch with their family members. Relatives told us they had frequent communication from the organisation and the home during the pandemic. Relatives commented "The home have kept us well informed of COVID -19 restrictions and instigated procedures for outdoor, then indoor visits when allowed," and "Emails were received regularly that updated the situation, I found these comprehensive and in my opinion acknowledged the difficulties of the situation and were written sympathetically to families. I felt decisions made were clear and logical".

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 had a duty of candour policy in place to support staff in meeting the regulation. The policy indicated the person or person acting on their behalf must be informed of the incident and this should be followed up with a written apology.
- The registered manager was aware of the duty of candour regulation and to be open and transparent when things went wrong.
- We requested the duty of candour letters for notifications which indicated the duty of candour was applied. These were in place and people and their relatives were provided with an apology following a duty of candour incident.

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 11 HSCA RA Regulations 2014 Need for consent The service was not working to the principles of the Mental Capacity Act 2005.

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 People were not safeguarded from the risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff were not suitably recruited in line with the provider's policy.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not mitigated, which resulted in safe care and treatment not been provided.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutritional and hydration needs were not met and risks around malnutrition mitigated.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service was not effectively managed and monitored to mitigate risks and provide safe care to people.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably inducted, trained and supported staff were not provided.

The enforcement action we took:

We served a warning notice.