Chalgrove Care Home Limited

Chalgrove Care and Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 19 and 20 October 2016. After that inspection we received concerns in relation to the safe management of swallowing difficulties, pressure area care and staffing levels. As a result we undertook an unannounced focused inspection on 30 May 2017 to look into those concerns. This report only covers our findings in relation to those. You can read the report from our latest comprehensive inspection by selecting the 'all reports' link for Chalgrove Care and Nursing Home on our website at www.cqc.org.uk.

Chalgrove Care and Nursing Home is a care home for up to 60 adults who require care due to illness or frailty. At the time of the inspection there were 50 people using the service, most of whom were older people. The Edwardian wing accommodates up to 35 people who require nursing care, and the Tudor wing up to 22 people who need residential but not nursing care. Accommodation is in individual bedrooms, some of which are large enough to share in the event a couple are admitted. The service operates a 'step down' scheme with some local hospitals, where people who no longer require acute care in hospital are admitted for further recuperation or until ongoing care is in place. Two nursing and eight residential beds are allocated to this.

The service had a registered manager, as required under the terms of its registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection we found shortfalls in relation to the safe management of topical medicines, such as skin creams and ointments. These were a breach of the regulations relating to safe care and treatment. We will review the management of medicines at the next comprehensive inspection.

At the last inspection we also found shortfalls in relation to care planning and record keeping. These were a breach of the regulations relating to person-centred care and good governance. We will review care planning and record keeping at the next comprehensive inspection.

At this inspection, people were positive about the care they or their relative had received. They said they got the care they needed, that their food was good and that there were enough staff to provide the care and support needed.

Systems were in place to manage the risk of choking where people had swallowing difficulties. These had been reviewed since concerns had been raised about safe swallowing. Commissioners had visited the service and made recommendations about the management of swallowing difficulties. The service was working to implement these.

The people we saw eating had been assisted into a more upright position to help them swallow without choking. However, one person, who had recently finished their first course of a meal, had slipped down the bed.

Staff had asked GPs to make referrals to speech and language therapists for people who had swallowing difficulties. However, records did not always show clearly when this was done and why.

Standard national descriptors of food and fluid textures for people with swallowing difficulties were not used consistently across the service. Safe swallow plans did not all reflect the standard national descriptors. These had been based on assessments from community or hospital speech and language therapists who had assessed people's swallowing difficulties. The professionals had not always used the standard national descriptors.

People's safe swallow plans were clearly displayed in people's rooms for staff to refer to when they assisted someone with eating and drinking.

Written information sheets that were used when people were admitted to hospital reflected the recommendations in safe swallow plans. However, these sheets did not show the date they had been created.

There were systems in place to protect people from developing pressure ulcers. For example, people who were at risk were supported to change position regularly.

Most records for prescribed creams contained the required information. There were clear instructions for administration, including body maps to show where to apply them. However, three records did not contain a body map or clear instructions. We will review the management of medicines, including prescribed creams, at the next comprehensive inspection.

There were enough staff on duty to provide the support people needed. Dependency tools were used to help inform staffing levels.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Systems were in place to manage the risk of choking where people had swallowing difficulties. These had been reviewed since concerns had been raised about safe swallowing.

People who were at risk of developing pressure ulcers were receiving the support they needed, such as assistance with repositioning and the provision of air mattresses.

There were enough staff on duty to provide the care and support people needed.

We could not improve the rating for safe from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Chalgrove Care and Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced focused inspection of Chalgrove Care and Nursing Home on 30 May 2017. This inspection was to look into concerns received in relation to the management of swallowing difficulties, pressure area care and staffing levels.

The inspection team comprised two inspectors and a specialist advisor. The specialist advisor was a speech and language therapist, who was able to advise the inspectors in relation to the management of swallowing difficulties.

Prior to the inspection we reviewed the information we held about the service. This included information from notifications of serious incidents and from stakeholders. We obtained feedback from the local authority safeguarding and service improvement teams and from the NHS Clinical Commissioning Group. We did not request a Provider Information Return (PIR) as this inspection took place in response to concerns. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with five people and a relative about their experience at the service. We visited 14 other people in their bedrooms who were not able to give much feedback due to their health conditions. One of them had their lunch in the lounge, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who cannot talk to us. We talked with a visiting healthcare professional, two registered nurses, five other care staff, a member of the kitchen staff, the registered manager, the provider's quality lead and another

member of senior staff. We reviewed elements of 18 people's care records, as well as the records for a person who was no longer at the service. We also checked staff rotas.

Following the inspection we reviewed information requested from the provider during the inspection, including the service's training matrix, details of induction training and policies and procedures relating to nutrition and hydration, medicines, and tissue viability and wound management.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we found shortfalls in relation to the safe management of topical medicines, such as skin creams and ointments, care planning and record keeping. These related to breaches of Regulation 12 Safe care and treatment, Regulation 9 Person-centred care and Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We will review the management of medicine, care planning and record keeping at the next comprehensive inspection.

Prior to this inspection we received information of concern in relation to the safe management of swallowing difficulties, pressure areas and staffing levels.

At this inspection, people were positive about the care they or their relative had received. They said they received the care they needed and that their food was good, with plenty to eat. Someone who was at risk of developing pressure ulcers told us staff looked after their skin, applying cream to their heels when these became red. Another person commented, "More than happy – 110%".

When asked about the help someone with swallowing difficulties got with their meals, the person remarked, "Nice staff". They explained how when they coughed on food or drink, the staff stopped feeding them and leant them forward on the bed. Another person with swallowing difficulties said staff helped them out when they coughed on food or drink, checking they were OK. During our observations, staff noticed when someone began to cough while they were eating and quickly came to make sure they were alright.

Systems were in place to manage the risk of choking where people had swallowing difficulties. These had been reviewed since concerns had been raised about safe swallowing. Commissioners had recently visited the service and made recommendations about the management of swallowing difficulties. This had included consideration of a screening tool to identify when a speech and language therapy referral was needed. The service was working to implement these recommendations.

People who had swallowing difficulties had safe swallow plans. Summaries had been written to handover to paramedics or hospital staff in the event of the person being admitted to hospital. The summaries were consistent with people's safe swallow plans, reflecting the requirements to reduce their risk of choking. However, they did not show the date they had been created.

Staff demonstrated good practice in supporting people with swallowing difficulties. They informed people what their meal consisted of, ensured they were in the correct position, and provided the degree of supervision needed. Whilst supporting someone to eat, they paced the offer of a new mouthful, waited while the person was still chewing and controlled the size of the mouthful.

People's drinks were, with two exceptions, thickened to a degree consistent their safe swallow plan. One drink in a person's room was thickened beyond the degree specified; the drink was solid in the glass whereas the safe swallow plan advised it should be syrup thick. There was potential for reduced hydration if this occurred often. However, the second drink in the person's room was thickened to the correct

consistency. Another person had a drink that was thinner than the recommended custard consistency. The person explained they preferred less thick drinks and usually only put one scoop of thickener in a glassful. They made their own drinks up in their room, and showed us how they did this. However, the mental capacity assessment for risks around them taking thinner drinks was not clear in their file. The deputy manager felt the person did have capacity to choose to have thinner drinks, and accepted that an up-to-date mental capacity assessment was needed to clarify the person's ability to make a choice around the thickness of fluids.

People with swallowing difficulties were provided with meals in accordance with their safe swallow plans. Where people required pureed food, different items had been pureed individually, maintaining their taste and visual appearance. One person who required thickened fluids had thin gravy on their plate. The nurse assisting them mixed this with the puree so the person was not put at increased risk by being given fluid (gravy) thinner than current recommendations.

People had been assisted into a more upright position to make it easier for them to swallow safely. One person had been positioned in accordance with the safe swallow plan recommendation at the start of their meal. When we saw them, they had recently finished their first course and were in a position indicating they had slipped down the bed. A member of staff entered and made ready to re-position them.

None of the safe swallow plans included reference to medication, for example whether people had been assessed as safe to take tablets as part of their speech and language therapy assessment. The service was aware of the lack of guidance regarding the administration of medicine for people with swallowing difficulties, and had recently written to people's GPs. The provider's medication management policy set out procedures for staff to follow to crush tablets and split capsules if there were no other suitable form of the medicine available for people with swallowing difficulties. This required authorisation by the prescriber and advice from a pharmacist. The provider's quality lead said the service would liaise with GPs and pharmacists about alternative forms of medicines if concerned about people's ability to manage tablets safely.

When supporting people with swallowing difficulties, it is best practice to use standard national descriptors to describe food and fluid textures. The use of standard national descriptors within documentation was inconsistent. This had implications for elements like the thickness of sauce or gravy judged to be safe. The provider's nutrition and hydration policy and guidance was dated April 2017. It reflected the NPSA standard descriptors for food textures and fluids. Two people's recent safe swallow plans used standard descriptors to specify the texture of their diet and the consistency of their fluids. However, another person's plan used a standard descriptor for fluids, but described food only as 'puree', as did the other people's plans. They did not specify whether the puree should be thick or thin. The descriptors used in safe swallow plans reflected the terms used by community or hospital speech and language therapists in their assessments of people's swallowing difficulties. These did not always match the standard national descriptors. Following the inspection, the registered manager advised us the service was getting people's swallowing difficulties reassessed where their safe swallow plan did not use the national descriptors.

Staff had asked GPs to make referrals to speech and language therapists for people who had swallowing difficulties, although records did not always show clearly when this was done and why. Care plans for two people stated they should have thickened fluids and a pureed diet, but it was not clear from the documentation how this decision had been reached.

We viewed the records for someone with swallowing difficulties who no longer lived at the service. They had a safe swallow plan that stated they should have custard thick fluids and pureed food. The record sheets were not consistent in reflecting the textures of food and fluid given, and contained less detail than the other

records we reviewed during the inspection. We will review record keeping at the next comprehensive inspection.

In the kitchen, there was clear information about swallowing difficulty diet needs on the wall. This matched the information provided in safe swallow plans and people's care plans. The chef said they had received training around two years ago about texture modified diets. They told us that if a new person arrived or someone returned from hospital then a member of care staff informs them of any new safe swallow diet requirements, either verbally or in writing. Plates for people with swallowing difficulties were labelled with the person's name and room number. The chef reported this had helped differentiate food types, such as 'blended' and 'pureed'. They explained 'blended' was used where people needed soft meals but did not have swallowing difficulties.

Two registered nurses told us they had received dysphagia training in their other work environments. They were able to state some signs and symptoms of dysphagia, such as coughing when eating, and describe the process for supporting people and investigating their swallowing difficulties. They were able to tell us about choking first aid (abdominal thrusts, clearing the airway, using suction), though they omitted back slaps until asked directly. One nurse said there were two suction machines in the home and that they had used one recently. They said the machines were always in good working condition when they had used them.

According to the training matrix, a registered nurse, a senior care worker and a chef had attended dysphagia awareness training. Almost all staff had had health and safety training within the past two years, which included emergency aid. The registered nurses told us dysphagia training for care workers and new staff was generally on the basis of the needs of individual people using the service. The registered manager reported there was no specific dysphagia training for care staff. Texture modified diets and first aid for choking were covered during induction training for care staff.

Systems were in place to manage people's skin care, including assessing their risk of developing pressure ulcers, care planning, the provision of equipment such as air mattresses and pressure-relieving cushions, nutrition and fluid monitoring, and applying topical creams.

Records of care given reflected that people at risk of developing pressure ulcers were getting the assistance they needed with repositioning, were being encouraged to eat and drink and that their air mattresses were regularly checked to ensure the setting was correct. People had received assistance to change position at least as often as specified in their care plan.

People told us there were sufficient staff to meet their needs. Those we spoke with said that if they used their call bell, staff responded and came to them in a reasonable amount of time. For example, someone commented, "Come as soon as they can; reasonably good – usually within a few minutes".

There were enough staff on duty to provide the support people needed. Dependency tools were used to help inform staffing levels. With the exception of one care worker being on sick leave, the number and range of staff on duty matched the assessed levels.

Both the registered and deputy managers told us there was some 'slack' in the system as the majority of cleaners had completed the Care Certificate and so where necessary could help provide care, for example, assisting people to eat. Staff could also be called upon to assist from the nursing to the residential side, and vice versa, in event of real difficulties.

The staffing structure had changed late in 2016. Prior to this, registered nurses had been responsible for

roles within Tudor, such as checking monitoring forms and giving medicines. Seniors care workers on Tudor were now delegated responsibility for these tasks. The deputy manager had trained the seniors and reported that it had worked really well. Staff we spoke with reported that Chalgrove Care and Nursing Home was a good place to work.