Chilterns Healthcare Limited

Chilterns Manor

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Chilterns Manor is a residential care home providing accommodation and personal care to up to 22 people. The service provides support to older people and people with dementia. At the time of our inspection there were 14 people using the service. Chilterns Manor accommodates people in one adapted building.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

People were not protected from the risk of avoidable harm. For example, portable heaters were in use in bedrooms. In one room, the radiator was extremely hot to touch and could have caused serious injury. Risk assessments had not always been put in place where risk was evident, for example use of anti-coagulant medicine to thin blood, use of bed rails and choking risks.

People could not be confident they would be repositioned safely by staff. Moving and handling competency assessments had been done under training scenarios where staff practiced on each other, rather than in real life situations where people's movements and behaviour are likely to be unpredictable. One person had been injured in an accident when staff had failed to provide their walking frame. We observed another person was poorly assisted getting off the stairlift.

People were not sufficiently protected against the risk of fire. The provider could not assure us recommendations in the fire risk assessment had been fully addressed or were in action. Fire drill records showed demonstration of what staff might do but did not indicate simulated rehearsal and obstacles they may encounter, so that these could be addressed before an emergency arose.

Medicines were not consistently managed in line with good practice. Two end of life medicines had not been logged in to the home. This meant there was no record of quantities received and would prevent accurate auditing of their use. Some entries on medicines records indicated they had not been given. When this was queried with the provider, they told us the medicines were not required. One of the medicines was an antipsychotic medicine, another a vitamin; both were prescribed for regular use therefore they should have been given.

There were sufficient numbers of staff on duty and recruitment checks had been undertaken. However, it was not clear how some new staff had been assessed as suitable where they had no background in adult social care and references and application forms did not provide information about suitability. We observed

staff with poor English skills and speaking in their first language in front of people. Staff did not always engage well with people. For example, we saw some staff standing up to assist people with drinks and meals, sitting on the arm of chairs and sometimes not talking to people whilst sitting next to them.

People could not be confident they would be protected from the risk of abuse. Incident reports did not always provide information about the extent of injuries referred to and who other people were who were injured or affected. The provider was unable to send us information to assure us people were adequately safeguarded when we asked for these details. We also found some of these incidents should have been referred to the local authority. We had not always been informed about all events the provider was obliged to report to us.

There was little evidence of engaging with people to consult with them and seek their views. Relatives reported communication from the home was still an area that needed attention.

Management oversight and governance processes were not robust enough to examine the quality of people's care and identify areas for improvement. Concerns we found as a result of the inspection had not been picked up as part of monitoring. There was a lack of understanding around risks to people and looking at care from people's perspective.

There was some evidence of contacting people when things went wrong. However, the provider did not fully act in an open and transparent manner (duty of candour) by offering an apology and saying what actions they would take to prevent recurrence.

Relatives expressed a mix of experiences of the home. Comments included "Always clean and well-fed and well-cared for," "No complaints, seem to be very kind" and "Staff seem very nice." Others told us there was no rapport with some staff and that staff did not engage well with people. Some themes where they felt there could be improvement included the poor condition of the garden and activity provision.

Improvements had been made to infection prevention and control measures.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection and update
The last rating for this service was Inadequate (report published 14 October 2022).

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the provider remained in breach of regulations.

At our last inspection we recommended the provider follow good practice where people lacked mental capacity. Improvements had been made in this area. A further recommendation was made to improve people's mealtime experiences. Actions taken were not sufficient.

Why we inspected

This inspection was carried out to follow up on action we told the provider to take at the last inspection.

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

For those key questions not inspected, we used the ratings awarded at the last comprehensive inspection to calculate the overall rating.

The overall rating for the service remains Inadequate.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led sections of this report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
We have identified continued breaches in relation to safeguarding people from abuse, safe care and treatment, recruitment practice, being open and transparent (duty of candour), governance of the service and notifying us of significant events.

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.

The overall rating for this service is 'Inadequate' and the service remains 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 of registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Chilterns 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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 1 inspector and 1 Expert by Experience. 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
Chilterns Manor is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Chilterns Manor is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority and professionals who work with the service.

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

We contacted staff by email but did not receive any replies.

We used all this information to plan our inspection.

During the inspection
We spoke with 2 people who used the service and 8 relatives. The Expert by Experience contacted relatives by telephone to seek feedback on the quality of people's care.

We spoke with a range of staff including the registered manager, deputy manager a senior care worker and housekeeping staff.

We checked some of the required records. These included care plans, medicines records, staff recruitment files and staff training and development files. Other records included those which related to monitoring and auditing of the service, minutes of staff meetings, accident and incident reports.

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.

After the inspection
We requested and received additional evidence from the provider to support our judgements. We continued to review this information until 16 March 2023.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question Inadequate. The rating for this key question has remained Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to assess the risks to the health and safety of service users and done all that is reasonably practicable to mitigate any such risks. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

• Staff did not always follow safe procedures when they assisted people to move. We observed a poor moving and handling manoeuvre which could have resulted in injury to the person. Another person had fallen recently after staff had failed to provide their walking frame for them to use.
• Moving and handling competency assessments had been carried out with staff practicing on other staff. This was not sufficient as it did not take into account the unpredictability of people's behaviour, movement and mood whilst being assisted.
• Risk assessments had not been put in place for all areas of risk. These included use of bed rails, anticoagulant therapy to thin people's blood and risk of choking.
• Portable electric heaters were placed in people's bedrooms. We went into 1 room where the heater was on. The surface temperature was exceptionally hot and the person in the room was unsupervised. The person had dementia, which could have decreased their awareness of the danger the heater posed. We asked staff to stop using these due to the risk of injury and alerted the provider to the risk of harm.
• Fire safety measures needed improvement. We were not given assurance all actions in the fire risk assessment had been completed. Records of fire drills were not sufficient to show staff had been adequately trained and rehearsed on what to do in the event of fire.

This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to assess the risks to the health and safety of service users and do all that is reasonably practicable to mitigate any such risks.

• After our inspection, the provider told us they had stopped using the portable heaters.
• We saw some improvements had been made to the environment. However, the garden remained in poor condition.

Using medicines safely

At our last inspection the provider had failed to ensure people's medicines were managed properly and safely. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

• Medicines were not always managed safely.
• There was no record of 2 medicines being received in the home. This meant it would be difficult to monitor and audit their use. They were stored in the controlled drugs cabinet although they were not drugs which were classed in this category.
• Medicines administration records were completed. We queried some entries where 'other' or 'make available' had been recorded. The provider told us these medicines had not been given as they were not required. One of the medicines was an antipsychotic medicine used to treat mental health disorders, another a vitamin. Both were prescribed for regular use therefore they should have been given.

This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to ensure people's medicines were managed properly and safely.

• Medicines competency assessments had been put in place since the last inspection, to check staff followed safe procedures. We were shown evidence of 1 assessment for each member of staff who handled medicines.
• Since the previous inspection, senior staff were no longer administering injections to 1 person (which they had not been authorised to do). This was now delegated to community healthcare professionals.

Staffing and recruitment

At our last inspection the provider had failed to ensure people were cared for by workers who had the qualifications, competence, skills and experience necessary for the work performed by them. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 19.

• Recruitment checks had been carried out for all staff. However, it was not clear how some staff with no experience of working in adult social care and who had limited English had been appointed to their roles. Their application forms and references did not provide assurance of their suitability.
• We observed some staff did not have the skills and experience to respond to people's needs. For example, 1 person asked for a foot stool so they could put their feet up. The member of staff thought they were asking for a book and asked which book they wanted. The person became agitated as their request was not understood. Another member of staff intervened.
• A relative commented "Some carers don't really understand English." Another told us there was "No rapport." Others had positive experiences; 1 relative told us "Staff seem very nice."
• Some staff had little or no interaction with people. For example, taking plates and cups away without asking and sitting next to people in the lounge and not engaging with them. One relative said "If carers are not doing anything, they sit in the lounge, not talking to them."

This was a continued breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to ensure people were cared for by workers who had the

qualifications, competence, skills and experience necessary for the work performed by them.

• The service had enough staff on duty to be able to meet people's needs.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

At our last inspection the provider had failed to protect people from the risk of abuse and improper treatment. Effective systems and processes had not been established and were not operated to investigate allegations of abuse. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

• Staff received training on protecting people from abuse and there were systems to report abuse. However, incidents had not always been reported to the local authority where people may have experienced harm.
• Incident reports did not always provide information about the extent of injuries referred to and other people who were injured or affected. The provider was unable to send us information to assure us people were adequately safeguarded, when we asked for these details.
• Some of these incidents had not been reported to the local authority. For example, where a person had threatened to hit another person and where another person had threatened violence to others on 2 occasions and made threats to anyone who got in their way.

This was a continued breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to protect people from the risk of abuse and improper treatment.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

At our last inspection we recommended good practice was followed regarding checking lasting power of attorney. The provider had made improvements.

• We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Preventing and controlling infection

At our last inspection the provider had failed to adequately assess, prevent, detect and control the spread of infection. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

regulation 12.

• We were assured the provider was preventing visitors from catching and spreading infections.
• We were assured the provider was supporting people living at the service to minimise the spread of infection.
• We were assured the provider was admitting people safely to the service.
• We were assured the provider was using PPE effectively and safely.
• We were assured the provider was responding effectively to risks and signs of infection.
• We were assured the provider was promoting safety through the layout and hygiene practices of the premises.
• We were assured the provider was making sure infection outbreaks can be effectively prevented or managed.
• We were assured the provider's infection prevention and control policy was up to date.
• Relatives commented positively on cleanliness. For example, one person said "It's a lot cleaner than it was, more uncluttered."

Visiting in care homes

Relatives told us there were no restrictions on them visiting the home. They were encouraged to continue wearing face masks whilst on the premises.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question Inadequate. The rating for this key question has remained 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At our last inspection the provider had failed to seek and act on feedback from relevant persons for the purposes of continually evaluating and improving the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

• The culture of the home was not person-centred, inclusive and empowering. There was little engagement with people about their care.
• We saw surveys had been completed with 8 people about their care. These were very basic, consisting of 5 questions and mostly yes or no answers. The registered manager sent us information about what had been done where some actions had been identified.
• The provider was unable to show us any further examples of consulting and engaging with people. They asked us how they could engage with people.
• Relatives told us they experienced poor communication with the home. Comments included "I don't know what's been going on, I get dribs and drabs," "Communication is not very good" and "Not great on keeping in touch."

This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to seek and act on feedback from relevant persons for the purposes of continually evaluating and improving the service.

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

At our last inspection the provider had failed to notify us of all events it was required to.
This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Not enough improvement had been made at this inspection and the provider was still in breach of

regulation 18.

• The provider had not ensured we were notified of all relevant events. This included safeguarding referrals. This meant we were not able to monitor whether appropriate actions were taken to prevent people being harmed further.

This was a continued breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009 as the provider had failed to notify us of all events it was required to.

At our last inspection the provider had failed to ensure systems or processes were in place to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

• Management oversight and governance processes were not robust enough to examine the quality of people's care and identify areas for improvement.
• Records of monitoring activity did not show any of the risks and concerns we found during the inspection had been picked up during monitoring. Breaches of regulation were still evident in several areas.

This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to ensure systems or processes were in place to assess, monitor and improve the quality and safety of the service.

At our last inspection we recommended the provider adopted good practice guidance in supporting people to manage their meals effectively. The provider had not made enough improvement.

• We observed several interactions at mealtimes or when serving drinks where some staff stood over people when they assisted them, rather than sitting beside them or bending down at the same level.
• In discussion with the provider about these findings, there was little appreciation of the effect this would have on people's enjoyment of meals.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

At our last inspection the provider had failed to demonstrate they acted in an open and transparent way and took appropriate actions to meet the duty of candour requirement. This was a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 20.

• We were shown some brief records of contact with relatives after some incidents. For example, an email consisting of 2 sentences. The records did not contain an apology or provide information about what would be done to prevent recurrence. They were more stating the fact that an accident had happened.
• The provider was unable to demonstrate the duty of candour principles had been followed after all incidents that we became aware of during the course of the inspection.

This was a continued breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to demonstrate they acted in an open and transparent way and took appropriate actions to meet the duty of candour requirement.

Continuous learning and improving care; Working in partnership with others
• The provider had worked with external agencies including healthcare professionals and the local authority. However, sufficient improvements had not been made in all required areas since the last inspection and people continued to experience poor care.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified us of all events it was required to. Regulation 18

The enforcement action we took:

Cancellation of 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 had not taken adequate measures to ensure the proper and safe management of medicines. The provider had failed to adequately assess the risks to the health and safety of service users and done all that is reasonably practicable to mitigate any such risks. Regulation 12

The enforcement action we took:

Cancellation of 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 The provider had failed to ensure systems and processes were established and operated effectively to investigate any allegation or evidence of abuse. Regulation 13

The enforcement action we took:

Cancellation of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure systems or processes were in place to assess, monitor and improve the quality and safety of the service. The provider had failed to seek and act on feedback from relevant persons for the purposes of continually evaluating and improving the service. Regulation 17

The enforcement action we took:

Cancellation of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured people were cared for by workers who had the necessary skills and had been recruited using effective processes. Regulation 19

The enforcement action we took:

Cancellation of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider had failed to demonstrate they acted in an open and transparent way and took appropriate actions to meet the duty of candour requirement. Regulation 20

The enforcement action we took:

Cancellation of registration.