Chrissian Residential Home Limited

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Inspection report

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Date of inspection visit:
25 May 2022
01 June 2022

Date of publication:
01 July 2022

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Chrissian Residential Home is a residential care home providing personal care to up to 22 people. The service provides support to older people, some living with dementia. The service is provided in one adapted building over two floors. At the time of our inspection there were 22 people using the service.

People's experience of using this service and what we found
We identified concerns with the environment of the home, several areas posed a safety and infection control risk and required improvement. We have been given assurances that the provider is taking action to address this.

The systems in place to assess and mitigate risk were not robust. People's care records did not consistently reflect adequate assessment, planning and evaluation of their individual risks to protect them and keep them safe. Since our visits the provider has developed an action plan and is working with an external consultant and relevant stakeholders to rectify this.

We received mixed feedback about the staffing arrangements in the home. We were not assured that the deployment and organisation of staff on shift fully considered the needs of people and supported them to safely move around the home.

The governance systems were not robust enough to support the provider and management team to independently identify shortfalls and address them. Following our visits, the provider has been implementing their action plan. These improvements need to be sustained, maintained and fully embedded into the culture of the home.

The provider had risk assessments and policies relating to the COVID-19 pandemic. People were supported to have visitors. Overall, 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.

Staff were recruited safely, had received safeguarding training and knew how to protect people from potential harm. Safeguarding policies and processes were in place.

Safe management of medicines were in place.

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 2 May 2018).

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

We received concerns in relation to risk management, records, safe care and treatment and the management of the home. As a result, we undertook an unannounced focused inspection to review the key questions of safe and well-led.

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

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Chrissian Residential Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment and good governance at this inspection. 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 work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Chrissian Residential Home Limited

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
This inspection was undertaken by two inspectors.

Service and service type
Chrissian Residential Home 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.

Chrissian Residential Home 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 service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection and sought feedback from the Local Authority. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We visited the service on 25 May and 1 June 2022. During the visits we spoke with six people who used the service about their experience of the care provided. We also had contact with the registered manager, the deputy manager, four care staff, a senior housekeeper, the provider's nominated individual and the owner of the home and briefly with the external consultant brought in by the provider after our first visit to address our concerns. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We observed people's care to help us understand the experience of people who could not talk with us. We reviewed a range of records. This included four people's care records and medication records. We looked at a variety of records relating to medicines management, infection control, health and safety, staff recruitment and management of the home.

Following our visit, we received feedback on the telephone from three relatives. We reviewed records relating to the governance and management of the service including audits.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

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

- Environmental risks including safety and infection control were not always picked up and appropriate action taken to ensure people's safety. We found an external area to the building was cluttered, unsafe access and a fire risk concern.
- Both stair cases in the building were a concern, the risk of falls had not been identified with adequate mitigation put in place. Relevant legislation and best practice had not been considered and implemented, for example Health and Safety Executive (HSE) guidance on Health and Safety in care homes. Residents were able to access the upstairs, could fall and this was not being monitored. We signposted the management team to the relevant HSE guidance.
- Internally we found several slips, trips and hazards in the home that had not been identified and made safe. For example, no visible signage from the lounge to the entrance of the conservatory to indicate a raised area where people could trip. One person's bedroom had duct tape on the entrance tread which was a hazard; it was in two parts and could cause a trip.
- We were not assured that risks to the health, safety and well-being of people were suitably assessed or appropriately monitored within the home. For one person, the use of motion sensor equipment had not been identified as a restrictive intervention and the rationale fully examined in line with the Mental Capacity Act 2005. For another person, their COVID-19 risk assessment did not consider or mitigate the risks of them sharing their bedroom with another person.
- Information in some people's care records to guide staff on how to best support them when they were distressed, frustrated and or at risk to themselves or others was inconsistent and limited in detail.
- People's care records did not always reflect the equipment people were supported with. This included the use of an air flow mattress, there was no information on what the setting should be for staff to monitor it was correct. Although other health professionals held responsibility for assessing this there were no agreed protocols to guide staff in the event of concerns or any malfunction.
- The hard copy record for people's personal emergency evacuation plan (PEEP) was not dated to show if they were current, accurate and relevant. The information did not provide staff with a visual and immediate way of identifying potential issues in an emergency.
- Systems for analysing safeguarding, complaints, accidents and incidents to learn lessons were not robust. Some documentation required archiving and several folders contained information that was not effectively organised and readily accessible.

The systems in place were not robust enough to identify shortfalls and assess risks and mitigate them. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider acted to make safe the fire safety concern to the external area of the home and on our second visit to the home we saw that visible signage from the lounge to the entrance of the conservatory to indicate a raised area where people could trip was in place. We also received assurances that the hazard to the person's bedroom had been addressed.

Preventing and controlling infection
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. There were infection control issues which had not been identified and mitigated in the home.
● There were two bathrooms in use at the home. One bathroom had missing tiles and was an infection risk. In the other, a wooden replacement side panel was loose. There was an increased risk of infection as the panel was unsealed and could cause damage to a persons' skin if they accidently fell.
● People's individual slings were stored inappropriately and at risk of cross infection.
● We found black mould on the glass of one of the ceiling sky lights on the first floor which had not been mitigated promptly. The glass in the other ceiling sky light was cracked with a broken seal.
● The shortfalls we found had not been picked up in the local audits completed.

The infection control systems in place were not robust enough to identify shortfalls. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We fed back our concerns to the management team about the safety of the environment and infection control on the first day of our visit. On our second visit to the home we saw that the provider had taken steps to mitigate risk and a programme of works to improve the environment of the home was being implemented. This was reflected in their action plan.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was 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.

Visiting in care homes
● We received feedback from relatives that they were able to visit their family members in the service.
● This was confirmed in our observations when people were enjoying visits with their relatives.

Staffing and recruitment
● We were not assured that staffing arrangements, including the organisation and deployment on shifts considered the environmental concerns of the home we had found and safely supported people to move around the home.
● We received mixed feedback about if there were sufficient staff to meet people's needs. One relative said, "The staff are always on the go, very busy, rushing around sometimes like headless chickens." Another relative said, "I have always found a member of staff or the manager if I needed to."
● We reviewed the recruitment records of three staff members and found checks had been made to reduce the risks of employing a staff member who was not of good character and unsuitable to work in the service. The checks included previous employment and Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely

● People were supported with their medicines where required. One person told us, "They [staff] get my medicine for me every day and help put my creams on my legs." A relative told us their family member, "Takes a lot of medication, the staff do really well to keep on top of it; am not aware of any problems." Another relative commented, "They [staff] know [family member] can sometimes be reluctant to take their medicine as they forget what it is for. They [staff] are good at explaining and encouraging them to take it."

● People received their medicines as prescribed including those on time sensitive drugs. Regular audits took place with any discrepancies addressed.

● Stock balances of medicines were recorded, and we saw these were an accurate reflection of the actual stocks held.

● Medicines were securely stored in designated medicine cabinets. Staff administering medicine had completed relevant training and had been assessed as competent to do so.

Systems and processes to safeguard people from the risk of abuse

● Staff explained how they would raise their concerns and the importance of protecting people from harm.

● There was information visible to staff in the service explaining how they could raise a whistleblowing concern should they have felt it necessary.

● Staff received training in safeguarding to provide them with the skills and learning needed for their job role.

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)

● Overall, 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.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Governance and monitoring systems were not robust and had failed to identify the shortfalls we found and ensure prompt appropriate action was taken. This lack of oversight put people at risk of harm.
- Areas of risk were not being effectively assessed and managed. Environmental audits had not identified and mitigated the safety and infection control concerns we found in the home.
- We found gaps in the risk assessment process where the impact of using equipment such as motion sensors had not been fully explored.
- We were not assured by the systems for monitoring and managing equipment such as air flow mattresses for people.
- Records in the home were not always accurate, readily accessible and dated to provide management and staff with the information they needed. Several hard copy folders such as health and safety, complaints and safeguarding required archiving.
- Management were not always clear on their job role and responsibilities.
- We were not always assured that a positive, person-centred, inclusive approach to care was being achieved.
- People's care records were not always consistent, and accurate or kept up to date to give staff the instructions they needed to provide person centred care.

The governance systems in place were not robust enough to identify shortfalls and address them. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We received positive feedback from relatives and people using the service about how caring the staff team were. This was confirmed in our observations. One relative told us that their family member received, "Kind and respectful care, manager and staff treat them like family." Another relative said, "I don't fault the care."

Continuous learning and improving care; Working in partnership with others

- We were encouraged by the action the provider was taking to address the shortfalls in the home and reduce the risk of people not receiving safe quality care. This included a planned programme of works to improve the home's environment, mentoring support for the registered manager from an external consultant and working with relevant stakeholders such as the local authority commissioning team. However, these improvements needed to be fully implemented and embedded into practice.

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

● Management and staff had regular team meetings and daily handovers. They discussed various topics such as any changes in people's needs or care, best practice and other important information related to the home.

● Records showed people and relatives were given the opportunity to discuss the home and make suggestions in meetings.

● Relatives told us they were kept updated by the home and felt informed about their family member's health and wellbeing. One relative said, "The staff and manager are great, very good at letting us know of any changes."

● There was a duty of candour policy in place which was understood.

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 12 HSCA RA Regulations 2014 Safe care and treatment The systems in place were not robust enough to reduce the risks of people receiving unsafe care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The governance systems in place were not robust enough to identify shortfalls and address them.