Porthaven Care Homes Limited

Chiltern Grange Care Home

Inspection report

Ibstone Road
High Wycombe
Buckinghamshire
HP14 3GG

Tel: 01494480294

Date of inspection visit:
23 April 2017
24 April 2017

Date of publication:
18 September 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on the 23 and 24 April 2017. Chiltern Grange Care Home is a registered care home that provides residential and nursing care to young adults, older people and people living with dementia. The home is registered to accommodate 75 people. At the time of the inspection there were 42 people living in the home. The home has three floors including the ground floor with lifts and stairs to all floors.

During the previous inspection in May 2016 we found breaches of Regulation 12 and Regulation 17 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.This was because people were not protected against the risks associated with the proper and safe management of medicines. Care related documents were not always up to date or accurately reflected people's needs. During this inspection we found continued breaches of these regulations and further areas of concern.

The home had been without a registered manager since June 2015. Although there had been a number of managers in place since this time, none had completed the registration process with the Care Quality Commission (CQC). At the time of the inspection a new manager was in post. They had started employment at the home on the 6 March 2017. They intended to register with CQC. 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.

We had concerns about the safety of the service, For example, people living with dementia did not always have supervision from staff.

Records related to care were not always up to date and accurate. Care plans did not clearly document changes in people's needs. Risk assessments were not always completed correctly. This placed people at risk of receiving inappropriate and unsafe care.

Staff recruitment was undertaken in such a way as to minimise the risk of employing staff who might be unsuitable to work with the people living in the home. Checks were made on the suitability and previous conduct of applicants.

Training, supervision and appraisals were provided to staff to encourage good practice and equip them with the skills and knowledge necessary to carry out their roles. Staff told us they felt supported in their role and they had received sufficient training to carry out their role competently.

The home was clean and odour free. The environment was comfortable and well maintained. Health and safety checks were completed to ensure the safety of the building and the wellbeing of the people living in the home, staff and visitors.

Staff did not understand the Mental Capacity Act 2005 (MCA) and how it applied to their role. Records did not demonstrate where decisions were being made on behalf of people who lacked the mental capacity to make their own decisions. The best interest process had not been followed. Mental capacity assessments were not always decision specific and these had not always been reviewed. People were not supported to have maximum choice and control of their lives. The policies and systems in the service did not support this practice. However, staff did support people in the least restrictive way possible. Where restrictions were in place to protect people's welfare, appropriate applications had been made to the local authority for authorisation.

Staff were caring, considerate and treated people with respect. We observed positive interactions between staff and people. People spoke optimistically about their relationships with staff.

We had concerns that personal information was not always stored in a secure way, which preserved the confidentiality of information. Records related to Do Not Attempt Resuscitation forms were not always completed correctly or accurately. People's preferences were not recorded clearly. This meant staff could not always be certain of people's end of life wishes.

There was a lack of personalised activities being carried out in the home, which meant people were not always protected from social isolation and a lack of stimulation. Plans were in place to increase the staffing in relation to activities.

Not everyone knew how to make a complaint. We spoke with the manager about this who said they would address this issue. Those complaints that had been made had been dealt with appropriately and in line with the provider's procedure.

The home had not been well led. The legal requirement to notify CQC of safeguarding concerns had not been carried out by the provider. With the introduction of a new manager, this had improved. Improvements had not taken place since our last inspection in some areas such as medicines and record keeping. Plans were in place to correct this situation.

People spoke positively about the new manager. Staff felt supported and relatives told us they had confidence in their ability. The manager had identified areas in the home that required improvement and had a plan in place to carry out those improvements. The Director of Nursing and Quality along with the manager were in discussions about how they could implement the necessary changes.

Some audits had been completed to ensure areas requiring improvements had been identified and we saw action had been taken. We found other areas of improvement had not been identified, and further work was still required to improve services to people.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

The deployment of staff did not ensure people could receive the support and care they needed at the time they needed it.

People were placed at potential risk, as medicines were not always administered on time, or in line with best practice.

The service ensured that people were protected from harm that could be caused by the building, equipment and grounds.

Is the service effective?

Requires Improvement

The service was not always effective.

People did not receive adequate support and encouragement at mealtimes. This placed them at risk of poor nutrition.

Not all staff were aware of how to implement the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Records showed people had access to health care appointments when needed. This ensured people's health needs were maintained.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were not always aware of the needs of people. This placed people at risk of receiving inappropriate or unsafe care.

Records related to Do Not Attempt Resuscitation were not always accurate or up to date. This meant people's end of life wishes may not be carried out or respected.

Staff displayed an affectionate and caring attitude towards people. People responded well to positive interactions from staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were placed at risk of receiving unsafe care, as risk assessments and care records were not all accurate or up to date.

Not everyone living in the home knew how to make a complaint. Information had not been shared with everyone to enable this to happen.

People and where appropriate some relatives had been involved in decisions and reviews of the care on offer in the home.

Is the service well-led?

Requires Improvement

The service has not always been well led.

Until March 2017 the home had been without a registered manager since June 2015. The lack of effective and consistent management in the home during this period had resulted in a reduced standard of care in some areas. A new manager is now in post.

Issues in the home related to staffing and record keeping had not been improved since the last inspection. A plan is now underway to address these areas.

Staff, people, relatives and professionals spoke positively about the new manager. They had confidence in their ability to support staff and make the necessary changes in the home, to improve the quality of care for people.

Chiltern Grange Care 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 checked 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.

This inspection took place on 23 and 24 April 2017 and was unannounced.

The inspection team consisted of two inspectors, a specialist advisor who was a Community Mental Health Nurse for older people with mental health problems, and an 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. Before the inspection we reviewed all the information we held about the service. We looked at notifications the provider was legally required to send us. Notifications are information about certain incidents, events and changes that affect a service or the people using it. We contacted and received information from the local authority safeguarding, contracts and commissioning teams. We also received information from the local GP surgery. We looked at all the information we have collected about the service.

For this inspection we did not ask the provider to complete a Provider Information Return (PIR). This 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. We gave the provider the opportunity during the inspection to tell us about this.

During the inspection we carried out the Short Observational Framework for Inspections (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 11 people, eight visitors, a health care professional, 21 staff including the manager and acting deputy manager, the Director of Nursing and Quality, permanent and agency nurses and care staff. We also spoke with the hostess, housekeeping, catering, maintenance, cleaning staff and the chef.

We looked at care records for 17 people; four staff recruitment records; 42 people's medicines and topical medicine administration records and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in May 2016 we found a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff did not follow the policy and procedures in regards to recording medicines and reporting medicine errors. We issued a requirement notice against the provider and requested an action plan. During this inspection we found these specific areas had improved, however we found other areas of concern related to medicines.

Prior to the inspection we had been made aware by the local authority pharmacist and safeguarding team of nine reported concerns related to poor practice in the ordering, administration and recording of medicines in the home. At the time of the inspection these issues had been addressed. We observed three medicine rounds in the home. On all three floors, we noted staff who administered medicines were interrupted throughout the process for various reasons.

Some people were scheduled to have their medicines at 8.30am however the dispensing of medicines was still in progress at 11am. One person was prescribed a controlled drug for pain relief; they were due to receive it at 8.30am we observed the administration of this medication at 11am. Likewise the 12.30 pm medicines round was still in progress at 2pm. This meant potentially some people were not getting their medicine at the right time. However, there was no indication that the time period between medication administrations was incorrect.

We recommend the provider reviews the systems in place to ensure the safe and timely administration of medicines.

Medicines were administered by nurses and trained care staff (Medtech). All staff who administered medicines told us they had received updated training and that their competency had been checked by the manager. This included agency nursing staff who administered medicines.

We checked the medication administration record's (MAR's) of the people living at the home we found them to be up to date and accurate. Photographic identification was available for all people receiving medicines and allergies were recorded. Where medicines reviews had been carried out by the G.P these were documented in care notes. Documentation for creams or lotions was available and we saw that administration records were up to date. Fridge and clinic room temperatures were recorded daily.

People told us they felt safe living in the home as there were systems and equipment in place to keep them safe. One person told us they had bed rails on their bed to prevent them falling out of bed. Another told us they felt safe because they had an alarm bell that they could press to alert staff to their needs.

Records related to care were not always up to date or accurate. For example in one person's care records a risk assessment had been completed regarding their ability to mobilise and their risk of falls. It stated the person was bed bound, however on the care plan evaluation sheet it stated the person had full mobility. We observed the person was in a wheelchair and therefore not fully mobile or bed bound. Staff told us the

person was at risk of self-harming. A risk assessment stated the person was at risk of injury because they banged and scratched their hands. The "Existing control measure" stated staff were "To report any bruises or wounds they find." This was not a control measure. Although staff knew how to support the person, records did not inform new staff or agency staff on how to do this. This may have led to inappropriate care and distress to the person.
Care plan files were extremely bulky and it was difficult to access information quickly. We found examples of contradictory instruction through all of the files. The care plans appeared to be evaluated at regular intervals but the evaluations did not influence a change in the care plans overall. For example, in one person's care plan we read a letter from the G.P who raised a concern regarding the person's risk of sepsis. It stated "Risk of sepsis with staff to observe for breathlessness, pale or blanched skin, increasing confusion." The record went on to state that should any of these symptoms develop, urgent medical advice should be sought. There was no information in any part of the care plan to inform staff of this risk. The resident information handover sheet for staff did not include information about the risk of sepsis.

Another person had behaviours that challenged the safety of themselves and others. We witnessed this during the inspection. The person had a chart that was used to record what happened before during and after the behaviour occurred. The purpose of this form was to identify the triggers of the behaviour and how the person responded to staff interventions. When we checked care records, the chart had not been updated. The daily record for the person did not record the person's behaviour. This meant staff had not recorded the necessary information to enable the person's behaviours to be analysed and understood. Without this understanding, the staff may inadvertently add to the anxiety of the person, leading to an increase of harm.

Records related to people's nutritional intake and fluid input and output were not always accurate or up to date. The tool used by the home to assess the risk of malnutrition was the Malnutrition Universal Screening Tool (MUST). In one person's file the calculations used to assess the risk had not been completed accurately. In another person's file we saw the Must was also incorrectly recorded along with incorrectly calculated records of weight loss. The malnutrition risk for these people was not adequately determined and managed. We spoke with the manager and Director of Nursing and Quality. They agreed that the record charts were inaccurately completed. Information in some care plans in relation to nutrition and hydration served no purpose and did not guide staff to provide appropriate care.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff understood the indicators of abuse. They were clear about the reporting of concerns and actions they needed to take to support people. A safeguarding flowchart was displayed at each staff desk, for staff to refer to when dealing with an allegation of abuse or neglect. We had received information from the local authority and other organisations of 16 safeguarding concerns which had allegedly taken place in the home since our last inspection. These had been investigated by the local authority.

Some people and relatives told us there was insufficient staff in the home. When asked if people, relatives and staff felt there were enough staff comments included "Usually not. I think they are short of staff." "Staff are magnificent but they rely too much on agency staff who are not as good as the regular ones." "Carers are lovely but they keep changing and I don't like changes all the time." Staff told us "We could do with more. You have to rush and we are not always catering for their (people's) needs" "Sometimes we don't have enough a third pair of hands would be helpful. When the med tech is doing the meds I can't be in the lounge and the dining room at the same time. It is difficult as people wander."

One person told us "Staff are always so busy. When they can, they have a little chat, but they get called away. …I can't get up and walk and the staff haven't got time to take me in out in the wheelchair. I feel guilty if I ask them to do anything."

On one day of the inspection, on the day shift, four staff out of twelve nursing and care were agency workers. The service requested agency staff who were familiar with the service, although this could not always be guaranteed. The continued problem with recruitment and retention of permanent staff meant, at times, staff were not always familiar with the people they cared for. This was evidenced when we asked the nurse in charge of the nursing floor for information related to people's care and they were unable to tell us or the information they told us was wrong.

On one floor some people required assistance with eating and drinking. Two other people persistently got up from their tables and wandered in the dining room and out into the hallway. The care worker who was supporting someone with their meal was repeatedly interrupted to escort the two people back to their table. On the second floor a person slept in front of their meal for one hour 17 minutes with staff intervention for two minutes. On another floor one person sat for 50 minutes with their meal without any staff support.

Staff during the morning and afternoon shifts were sometimes rushed and not always able to spend time effectively interacting with people. At less busy times, staff were able to sit and speak with people. At times during our inspection, staff were not within the vicinity of the staff desk or the communal area. We observed people who lived with dementia roamed about without the direction or reassurance of staff during these periods. People were at risk when staff could not readily be found by them.

We noted staff responses to people's call bells were sometimes delayed. This was evident when staff were already engaged in other tasks. This meant the person may have experienced an unnecessary wait for the assistance of staff. We observed staff had difficulties managing people's needs during a meal service. As both care workers were busy at the dining room area, the cleaner had taken responsibility for the transfer of the person from their chair to a wheelchair. At the time of the inspection the cleaner had not been trained to do this. Following the inspection they received training in moving and handling people.

We recommend the provider puts systems in place to ensure the effective deployment of staff to ensure people are responded to in a timely way when needing support.

Following the inspection and feedback from staff, we were told by the manager they had increased the staffing levels on the nursing floor. They were going to look into the staffing levels on the other floors and adjust if needed in relation to people's needs.

We noted all areas of the service were clean and odour-free. We observed cleaners and the tasks they undertook. They had a good knowledge of the national cleaning code. Chemicals were safely stored on their cleaning trolleys. Safety data sheets (used for chemical spills or incidents) were available for all products. The cleaners knew where these were located.

Recruitment systems were in place to ensure people were protected as far as possible from unsuitable staff. Checks included Disclosure and Barring Service (DBS) checks, written references, health declarations, and proof of identity and of address.

We found appropriate environmental risk assessments were conducted, reviewed and filed in relation to the building, equipment and grounds. Maintenance records we viewed included the fire risk assessment, gas safety certificate, amongst others. The fire authority had conducted a check of fire safety in January 2017

and found the service's assessments and maintenance checks were compliant with the relevant legislation.

Requires Improvement

Is the service effective?

Our findings

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. The application procedures for this in care homes are 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 were being met. The manager had identified where people had been deprived of their liberty to ensure their safety and wellbeing. They had applied for authorisation from the local authority to apply DoLS.

Staff asked people for consent before they assisted them with care. There was a mixed ability of staff to demonstrate an understanding and knowledge about the MCA and how this applied to people's lives. However, the service did not always operate within the requirements of the Act. Written consent of people or their representative to various aspects of care was not provided appropriately. Some people but not all had signed their own consent forms. However, in some instances, relatives who did not have the legal authority to do so had signed on behalf of people.

The manager maintained a record of the five people whose representatives held power of attorney for health and welfare. This meant the person's appointed attorney could legally consent and make healthcare decisions on the person's behalf. Documents showed this had occurred in line with the MCA. Some people had mental capacity assessments completed to determine whether they could provide consent to care. We found they were unsatisfactorily completed. They were not decision specific, contained sparse details and had not been repeated where a person's capacity to consent fluctuated.

We checked people's files to determine whether decisions were made in people's best interests. For example, documents showed decisions were made without consultation of relevant people. For one person there was no relevant mental capacity assessment to determine the person's ability to consent and no best interest decision documented. There was also a requested review of the decision after a set period of time documented, but this had not occurred.
Three people were receiving covert medicines. This is where the person's medicine is hidden in food or drinks, because otherwise they may refuse to take them. The Mental Capacity Act 2005 code of practice had not been followed. There was no documentary evidence of a mental capacity assessment or a best interest meeting having taken place or of the pharmacist being consulted about the safest way to administer medicines covertly. This was not in line with the Mental Capacity Act 2015 or The National Institute for Health and Care Excellence (NICE) guidelines.

.
The manager told us that the service had completed and submitted people's applications for standard DoLS

authorisations as a requirement of the MCA. They were awaiting decisions regarding them. Staff we asked were unsure about which people had DoLS in place at the time of our inspection. In people's care files it was not always clear to staff whether a person required a DoLS application, was awaiting authorisation of one or whether one was granted. In one person's file, we saw an 'emergency' DoLS was granted by a former staff member. The DoLS was authorised for 10 days, however the maximum period the service could impose itself was seven days. This was in conflict with the MCA, DoLS requirements and associated codes of practice.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we spoke with the manager at the inspection, they were aware that processes pertaining to consent, the MCA and best-interest decision records required improvement. They explained their intention to have dedicated supervision sessions with staff about the MCA and DoLS. They showed us a copy of the specific supervision record they had designed for the purpose. We reviewed one care file with the manager to check consent and best interest decision recording. We saw an appropriate mental capacity assessment was recorded for a specific decision. The best interest of the person was also documented. This was completed shortly before the inspection, and demonstrated that the management team were aware of the issues about consent to care and treatment and aimed to ensure people's rights were maintained.

Three people were assessed as being at risk of malnutrition. None of the people had a nutrition chart in place to monitor what they were eating. Two had fluid charts in place for staff to record their fluid intake. One person didn't. Both had fluid intake targets of what they should achieve each day. There was no explanation of how this target had been established or what action to take if the target wasn't reached. For one of these people records showed they had developed a pressure sore, however the care plan remain unchanged. There was no detailed care plan on how to manage the sore.

Not everyone who was at risk of choking had management plans in place to reduce the risk of choking. We saw two people had been assessed as at risk of choking. There was no guidance for staff on the action they should take if a person choked or how the person should be supported with food or fluid intake to minimise any associated risks.

A resident handover sheet gave a summary of people's needs, and was used as an aide memoir for all staff. The resident handover sheet did not state any of these people had risks of choking, or that one person had a pressure sore.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

For some people when a choking risk was identified, the GP was alerted and appropriate referrals were made. A speech and language therapist assessed the person and determined what 'stage' of fluid that the person should have. The storage of fluid thickening products was appropriate within dining rooms. There were lists of people's fluid stages taped to the inside of kitchen cupboards. This assisted staff who were required to prepare them. Staff we asked knew how to prepare the thickened fluids, and what products to use.

We found some people were provided with appropriate nutrition and hydration, and their opinion of the food was complimentary. Menus were clearly displayed inside and outside dining rooms. However, alternative forms of display for people with dementia were not provided. When we spoke with kitchen staff, they were aware of people's preferences, likes and dislikes with food and drinks. Kitchen staff were aware of

allergens in food they provided. The chef showed us a board used to record people's specific food allergies. When we reviewed one person's file, they were noted to have an allergy to crustaceans. However, when we visited the kitchen this was not known to the kitchen staff. We alerted them to this and they said they would take action to ensure the person's allergy was appropriately recorded. We saw that people had access to drinks in their rooms, in communal areas and were offered drinks regularly by staff. Jugs of fluid were replenished throughout the day. Snacks were readily available in communal lounges, and included healthy choices like fruit but also calorie-rich choices such as pastries. This ensured people at risk of malnutrition or with dementia could have small, frequent portions which would contribute to their weight management. People had meals in the communal dining room, although could choose to eat in their bedroom.

.

We found various external professionals were involved in assessing, planning, implementing and evaluating people's care and treatment. This included GPs, dietitians, speech and language therapists and physiotherapists. One relative told us "Dad has been on the second floor for about three years. The care is brilliant. Three or four months ago he had a bad chest infection and he went to hospital by ambulance. When he was in hospital he asked to come back here as the care was good." People's access and offer to some healthcare professionals, such as dentists and opticians, was not always recorded and required some improvement. Overall, the service ensured care support from community healthcare teams, which promoted the person's overall health.

Staff told us they felt they received sufficient training to carry out their role. New staff attended an induction which included training deemed mandatory by the provider. They also completed the Care Certificate. The Care Certificate is based upon 15 standards, health and social care workers need to demonstrate knowledge and competency in. Their competency was assessed by the senior staff. Following induction new staff shadowed more experienced staff until they felt confident to work alone and were deemed competent.

Further on-going training to update staff in skills and knowledge was available. This included areas such as safeguarding adults from abuse, health and safety and MCA and DoLS amongst others. Specialist training was made available to staff to bring their knowledge up to date on areas such as diabetes and dementia training amongst others. One staff member told us "Training and knowledge is never enough for me. If it is something new I enjoy it. I want to learn as much as I can." Another told us "I am always training; I am half way through the care certificate. A lot is common sense."

Staff were supported with supervision and appraisals along with team meetings and daily meetings. The manager showed us records to verify that since they had arrived at the home they had concentrated on ensuring staff received supervision which was relevant to their role. They had carried out group supervision about basic care, including standards and expectations. The manager had placed importance on carrying out supervision as they felt the staff team had gone through a lot of change and they wanted to share with staff their ideas and get to know staff and the issues they were facing in their work. In this way they could implement relevant changes where necessary.

Requires Improvement

Is the service caring?

Our findings

People and relatives comments about the care staff included:" Staff are fantastic" "They (staff) are very kind here." "My mother is well cared for. It's a very nice place and staff seem caring… [Named nurse] is very good but has not been here so much recently." "I have never found dad unwashed or with dirty Inco pads; he never has stubble. The night staff help him to shave and get up as he is an early riser." "It is a very nice place and the carers are fantastic they are so lovely."

We looked at do not attempt resuscitate decision making ('lilac' forms). Although GPs normally lead this aspect of care, the service had not ensured clear and consistent choice or involvement of people and their relatives. We found numerous examples where the completed 'lilac' form was inaccurate or incorrect. For example, in one file the person's resuscitation form was from a former address which rendered the decision as historic and had not been made following admission to Chiltern Grange Care Home. In another person's file, the 'lilac' form was dated 2011 and had not been completed or reviewed since. Another person's 'lilac' form did not contain the signature or date of a GP or other authorised healthcare professional. This meant staff would be uncertain in an emergency whether to perform cardiopulmonary resuscitation (CPR) or not. Another person's file contained two do not resuscitate forms; one dated two days after the other and both recorded different decisions about what to do in an emergency. Other forms recorded that a relative was consulted, but did not state whether the person was considered as part of the process for the decision made. People's ability to participate in decision making regarding resuscitation for a cardiac arrest was not satisfactorily managed or recorded. This meant people's wishes or plans for their end of life care may not be respected.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Confidentiality of people's personal information was not always maintained at the service. Opposite reception, there was a large whiteboard outside an administrator's office. This contained people's names and room numbers. The door was open at the commencement of the inspection. Visitors could easily note content from the board. At times, in communal lounges, care workers completed daily records. For example this included records of people's hygiene, food or fluid intake and activities. On multiple occasions we noted these folders were left out on tables in lounge areas without staff present. Again, visitors to the service could access sensitive information about people in the absence of staff. On notice boards near the staff desks, information about people and relatives was posted. These were instructions about particular people's care. This meant personal and confidential information about people was not stored or protected in line with the Data Protection Act 1998. As a result people's privacy was not protected.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives were encouraged to share their views about the service. Records showed people's relatives where appropriate had been involved in decisions or reviews that had taken place in relation to

people's care. Relatives were also invited to meetings with the manager to discuss the care being provided and any changes to the service. Relatives told us they felt communication between themselves and the manager had improved since the new manager had come into post. We observed but did not participate in a meeting between the manager and a relative of someone living in the home. This was to directly discuss the person's care needs and how they could best be met.

The first edition of a service newsletter was available for people and relatives to read. This included a formal introduction to the new manager, information from residents' and relatives' meetings, recognition of staff achievements and introductions and information about people. The manager stated that one of the areas for their focus was to meet people's expectations. This was highlighted in the service newsletter which stated there would be continued meetings where people and relatives could have a say about aspects of care and support.

Staff demonstrated respect of people's privacy when personal hygiene care was provided, by closing bedroom doors and curtains. We observed staff knock on people's bedroom doors when they were closed. We saw staff announced their presence and sought consent from people to enter their rooms. We saw staff called people by their name and treated them with respect when they provided care. Staff wore distinctive uniforms which people could use to determine their respective roles. Staff we observed also wore name badges so people and visitors could identify them by. We discussed with staff how they preserved people's dignity and how they treated people with respect. Their comments included "When carrying out personal care there are no open doors, curtains people are not naked I cover them with a towel. I offer to assist them but let them try to do what they can for themselves, but not in a way that will make them angry. I help them if needed." "I have seen people treated like they are kids, I am treating them like adults." "I respect them, I respect their decisions, and I don't push them to do something they don't want to do. I ask if I can help them." "I treat them how I wish to be treated. If they don't want to do something I respect their decision."

Throughout the inspection we observed positive interaction between staff and people living in the home. Staff communicated with people in fun and respectful way. When staff were dealing with people who were distressed or anxious, they were gentle and supportive in their approach. Staff showed patience when accommodating people's needs. For example, we observed during breakfast on the first day of the inspection a person asking for a cup of tea. The hostess brought the drink and asked the person if it was alright for them. The hostess stated "If it's not right we will do it again and again. We will keep doing it until it is right for you." The person confirmed the drink was to their liking. We observed a person holding a member of staff's hand. They were dancing together and were talking about folding the napkins together.

Requires Improvement

Is the service responsive?

Our findings

During our previous inspection in May 2016 we had concerns that people who used the service were not protected against the risks associated with inaccurate and incomplete records. This included a record of the care and treatment provided to people and the decisions taken in relation to the care and treatment provided. The provider was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found there was a continued breach of regulation 17.

A staff information sheet was used at handover, its purpose was to give up to date information on people and their needs, and to assist agency staff to ensure staff were aware of people needs with any concerns or particular risks. Risks to people when eating and drinking were not always highlighted two people who had pressure sores were not shown as such on the handover sheet. One person has a pressure sore on both heels and was diabetic; this information was not detailed on the handover sheet.

Daily care records and notes from shifts by staff were recorded in a single folder. Some forms in the folder used codes to indicate the care people received during the day. There was no key or legend, other than 'R' at the base of one form which indicated the person refused the care offered. We asked three staff if they could interpret the codes for the various aspects of the care. We were able to determine that 'W' meant a wash and 'S' referred to a shower, but other codes were used which were unable to be explained. We noted some records of care also contained crosses and dashes. Staff could not tell us what any of the unknown codes in the care records meant. It was unclear from the records what care people received on certain days. In the daily notes, task-based recording of care was evident. People's care details seldom focussed on their experience of the day, mood or attitude, pain, activities they participated in or their behaviours. Instead, care notes focused on the person's hygiene, what they ate or drank and what they wore. Care notes often contained the phrase 'no concerns'. People's care was not documented in a person-centred manner.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had information on how people had spent their time prior to admission to the home and included their interests and hobbies. However, there was little evidence that this information was acted upon. People being cared for in bed did not have individualised plans, some care plans said they had "One to one" but there was no information of what that entailed. Staff appeared to be uninvolved with how people spent their time and had little knowledge of the existence of life history and how people preferred to spend their time. For example, one person's life history stated they liked romantic novels and country and western music, their activities evaluation read "She does not like to do activities, prefers not to do activities, has 1:1 chats." We observed the person did not have any stimulation by the way of music, radio or television. There was no access to talking books. Therefore, no provision was being made for them to maintain meaningful interests.
Care plan and evaluations about how people spent their time did not reflect personal choice. For example in one care plan titled Work and Play, it stated that "X doesn't like activities", the aim was "For X to enjoy the daily activities," this was followed by the action "Even if he doesn't like to join in activities staff must

encourage him to join in the activities". We discussed this with the manager and the Director of Nursing and Quality. They agreed the records did not reflect the person's choice was being respected if staff were to encourage the person to participate in activities against their will.
We recommend the service increases the opportunity for people to participate in activities that are relevant to their individual interests.

People told us there were activities on offer within the home. One person said "My son came to see me and joined me for lunch. Neighbours come in and had lunch with me they paid for their lunch. My visitors are always offered a cup of tea. I have learned to knit again since I have been here." Another person spoke to us about their pots of flowers outside their bedroom that they had brought from home. They said they used to like gardening. We asked if there were activities for gardening that they could join in with, they told us they could not be bothered to do so. They told us "They (staff) always ask me to go on outings. I never go." A relative told us "'Dad likes the church service here and his vicar comes to visit him sometimes." Other people told us they did not want to join in the activities, but gave no indication as to why.

There was an activities and wellness programme. This was clearly displayed in the building and throughout the service. We noted that a wide range of activities were offered from Monday to Friday and these were reduced at weekends. There were some unique activities planned. For example, we saw that a virtual reality session was held before our inspection. There were trips into the community and a library trolley was provided so people could choose books to read each week. On the first day of our inspection although the programme guide indicated planned activities like puzzles, crosswords, knitting and reading we did not witness care staff actively encouraging these interactions. Instead, we observed people sitting in their bedrooms or communal lounges.

Some people knew how to make a complaint. One person and their relative told us they did not. The manager told us they would address this to ensure everyone knew how to make a complaint. The manager kept a log of complaints which recorded the nature of the complaint and what action had been taken to address the complaint. We could see complaints were dealt with in a timely way and in line with the provider's procedure. Comments from people included "I complained because I lost two nighties from the laundry, they were not marked. I now have a marker pen. No other clothes have gone missing." "Since [name of manager] has been here if we complain about agency staff they have not been here again." Staff knew how to deal with complaints and were aware of the need for reporting concerns to senior staff.

Requires Improvement

Is the service well-led?

Our findings

One relative told us "[Named manager] is a breath of fresh air, her commitment is fantastic. She responds to emails on the same day. She has worked every Saturday since she has been here." Other comments included "The new manager seems very good and wants to improve things. We are comfortable raising concerns with her." "Some things have improved already since the new manager has been in place, such as there are now breathing dogs and a fish screen saver for residents." (Breathing dogs are soft battery operated toys that give the appearance the dog is breathing.) One staff member told us "She is always with us; she is always asking if we need anything. She is new and gives us lots of information. She is knowledgeable and shares that with us. We have seen changes for the better since she came. For example, in the morning handover, the night staff now tell us about everyone on the floor. She has changed the resident information sheet. Things are much better…She [manager] left her number with us she told us if there is anything you don't understand just call me…She finds time for everyone".

There had not been a registered manager in place at Chiltern Grange Care Home since June 2015. Although managers have been employed in the service this has not resulted in them being registered. The lack of effective and consistent management in the home over the past year had resulted in a reduced standard of care in some areas. These have been highlighted throughout the inspection report. However, a new manager was employed on 6 March 2017. It was evident through discussions with the people we spoke with throughout the inspection process; the new manager was aware of the shortcomings we found in the home and was realistic about the time needed to implement improvements.

Prior to the inspection the manager had identified the deficiencies within the home and had plans in place to drive forward improvements. Some changes had already been implemented. For example, they were holding staff supervision sessions with groups of staff to discuss and explain how systems in the home were to be improved and to ensure staff understood the basic requirements of care. When we spoke with the manager they told us "I don't think the home is anywhere near where it needs to be from my perspective….I want to support staff, residents and managers."

Prior to the inspection and the appointment of the current manager we had received information from the local authority and other organisations of 16 safeguarding concerns which had allegedly taken place in the home since our last inspection in May 2016.The registered manager or the nominated individual is required by law to notify the CQC of such concerns. Prior to the new manager being in post we had received two safeguarding notifications from the provider. It was important the provider kept CQC aware of concerns in the home, to enable us to have an overview of what was happening in the home, and the action taken by the provider to protect people from abuse. Without this information it meant we could not be confident people were being protected. The provider failed to carry out their legal responsibility of notifying the commission of concerns in the home.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The service had not ensured the information in people's care plans were accurate, up to date and relevant.

Records did not consistently demonstrate the service had identified and assessed monitored and mitigated risks to people's health, safety and welfare. Changes in people's care needs were not always recorded. This was evidenced in nutritional records, medicine records, risk assessments and best interest records. People were placed at risk of receiving inappropriate care.

The manager told us they were aware of the situation related to ineffective care plans. The provider was planning to introduce an electronic care planning record. They hoped this would alleviate the duplication and storage of irrelevant information and assist staff to focus records specifically on people's needs. In the meantime they were going to review the information held in care files and remove outdated and inappropriate information.

Audits at the home had been completed. Documents showed an accident log had been kept; the information held within the log was reviewed by the manager to ensure where possible the risk of repetition was minimised. Infection control audits had been completed in March 2017. Action plans were in place to improve good practice in relation to infection control. Medication audits had been completed; action was taken immediately when the fridges storing medicines were found to be faulty. Two new fridges had been ordered.

Although audits had been completed not all the concerns we found during the inspection had been identified by the provider. The manager told us they were clear they would need time to put things right. We saw evidence they had started to implement changes, but this would take time due to the amount of work and changes needed to bring the service up to standard.

We were aware the provider was working through an action plan with the Clinical Commissioning Group (CCG) and the local authority to demonstrate improvements in the service. Visits and meetings had taken place to discuss with the provider and manager how and when the improvements were being implemented. Staff felt improvements had been made, one told us "It is a lot less stressful now, I feel less stressed. She [manager] is putting things into place; she has bought a DVD of fish and a coral reef, a stereo for the lounge, new denture pots, which I have been asking for a long time. She is doing ok." The manager emphasised to us their determination to improve the service to people. We received assurance from the provider the manager would receive support and resources to make the changes necessary in the home.

Some staff told us they were relieved at the appointment of the new manager, they felt their appointment offered the home some stability. Comments from staff about the qualities of the new manager included "She is everywhere all the time." "She knows her job she is very organised." "I think she [manager] could be good for us. She listens to what you have to say, she doesn't shut you down. She has made time for me. She will always come back with an answer, she will always find out if she doesn't know the answer." The manager told us "As a manager this is not about me directing staff. I want to embrace their ideas. Everyone wants to know they have a voice, I have said if they have an idea and it is viable I will give it a go."

It was clear from discussions with the manager and the Director of Nursing and Quality they were aware of the problems the home had faced over recent years. Both were new in post and were enthusiastic to see overall improvements in the home. They were keen to support staff through the changes and were planning innovative ways to recruit and retain staff. One staff member told us "Staff morale is half and half. It has improved from when the managers swapped. A lot of staff weren't happy before, they are happy now."

Where necessary, the maintenance technician and management took steps to mitigate risks whenever they were detected. We found evidence that two issues with building safety were satisfactorily detected and appropriately acted upon. There was an issue with one gas boiler. This was singled out by contractor checks.

The maintenance technician had followed the contractor's requirements. However, the staff member was still concerned about the safety of the equipment being left in operation. The maintenance technician assessed there could still be a risk to people. The staff member organised the disconnection of the boiler until appropriate repairs were made to ensure safe operation. This meant that through the completion of quality checks the service had identified and acted appropriately to ensure the safety of people using the service.

People who lived in the home had been sent a quality assurance questionnaire. At the time of the inspection only two responses had been received. Residents and relatives meetings had been held to discuss the running and changes in the home. The manager told us they were receptive to people's feedback. Staff were able to feedback through supervision, contact with the manager and staff meetings. Staff felt they were listened to and felt comfortable bringing forward new ideas or new ways of working. When we asked staff what was the best thing about working in the home they replied "Staff are good, they have all been good even the new ones." "The team, they try to do their best, they like what they do, they try to help everyone." "When it is not so demanding, when everything goes smoothly you have time to laugh with the residents, you have time to talk to them." They were all clear the aim of the service was to provide the best quality care they could for people. Something that was echoed by the new manager.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify the Care Quality Commission of safeguarding concerns within the service. 18 (1) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure the care and treatment of people was appropriate, met their needs, and reflected their preferences. Records related to care did not reflect people's needs. 12 (1)(2) (3) (a) (b) (c) (d) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to comply with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. 11.(1) (2) (3)

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 Records related the care being provided were not always accurate up-to-date and relevant to the care being provided. 12 (1) (2) (a) (b) (c) (g)

The enforcement action we took:

We imposed a positive condition on the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to protect personal information related to people living in the home. The provider failed to adequately assess, monitor and mitigate the risks relating to the health, safety and welfare of people and others who may be at risk which arise from the carrying on of the regulated activity

The enforcement action we took:

We imposed a positive condition on the registration of the provider.