Mrs Jacqueline Brown

Chy Byghan

Inspection report

Sunny Corner Lane
Sennen
Penzance
Cornwall
TR19 7AX

Tel: 01736871459

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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

We undertook an unannounced focused inspection of Chy Byghan on 12 February 2018. This inspection was undertaken following information of concern received by the Commission regarding the safety of the service. The team inspected the service against two of the five questions we ask about services: is the service safe and is it well led?

The service was rated as Requires Improvement at the last inspection in March 2017 when we identified three breaches of the regulations. We identified concerns included how the service operated under the Mental Capacity Act (2005) and concerns about the submission of Deprivation of Liberty safeguard applications to ensure people were not unlawfully detained. We also identified that the provider was not fully assessing the risks to people or doing all that was reasonable practicable to mitigate any risks. We identified that staff were not receiving the appropriate level of support, training or supervision to enable them to safely carry out their duties.

Following the last inspection in March 2017 the service sent us an action plan stating what action it was taking to meet the requirements of the regulations. This inspection is based on information about increased risk which preceded the planned inspection visit to check on the action the service had taken to meet the requirements of the regulations.

People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Chy Byghan is a care home which offers personal care and support for up to 19 predominantly older people. At the time of the inspection there were 13 people living at the service. Some people were living with physical disabilities, long term physical health and mental health conditions including dementia.

At this inspection we found concerns with the safety of fire systems. For example, the fire protection system was not currently operating as designed. For example the provider told us a heat sensor had been disabled by an electrician in November 2017 because it was defective and a fire exit had been closed off. The service did not have a fire safety risk assessment in place potentially putting people at risk of harm. We found issues with the safe running of the electrical system. The electrical system was repeatedly 'tripping off' and cutting the power supply. There was currently a high loading on the electrical system due to the use of four electrical heaters in various rooms. When the electricity supply was cut off the pressure relieving air mattresses used by one person deflated putting people's skin integrity at risk, and where people were dependent on electrical heaters for warmth, these were not available to provide heating during these periods. A fire door on a person's room on the ground floor was kept open with a wooden wedge. The person who used this room required the use of oxygen dispensed from a cylinder. The failure to keep the fire door shut when oxygen was being used posed a fire risk to all those using the service.

We had concerns about the provision of adequate heating to people living at Chy Byghan and the risk this caused to the service users of becoming cold. There was a fault with the heating and hot water boiler. The boiler fault meant that three bedrooms and the lounge were currently not being heated by the radiators served by the boiler. The current heating arrangement in the rooms which were not being heated by the central heating system, was through the use of portable electric heaters. These radiators were not always sufficient to keep these rooms at an adequate ambient temperature. The lounge particularly did not have adequate heating from the available electric heater.

Nine rooms including two bedrooms upstairs did not have a supply of hot water. This meant staff had to carry hot water upstairs in order to provide personal care to a person who was cared fr in bed and very frail. The hot water available across the rest of the service was checked and found to be only available at a tepid temperature. Maintenance records showed that the gas boiler had not received an annual service since June 2016. This meant that service users did not have an adequate supply of safely delivered hot water in order to meet their needs.

We had concerns about current and future appropriate staffing levels for the service. This was because one-third of the current core staff group had resigned because of uncertainty about the financial security of the service. The provider was heavily reliant on agency staff to maintain the staffing rota. On the day of inspection the service was already one staff member short of the three staff members usually allocated to cover the morning shift from 8:00am to 2:30pm. We saw that one of the remaining two staff had to leave the service for one hour and forty-five minutes during the morning, leaving only one staff member available to provide care and support for 13 people. Staff told us they did not consider the service to be safe because of the current level of staff absence and uncertainty about the future of the service.

Overnight staffing cover was limited to one member of care staff to provide care and support to 13 residents. The staffing rota showed that the night period was planned to be shared by two staff members on seven occasions between 12 February and 14 March 2018. Staff told us these shifts were having to be shared because the staff responsible for care overnight were also needed to cover for the day shift on the following day. Therefore these staff could not cover the entire night shift if they were to have enough sleep to work the following day. We saw that one staff member worked from 2:00pm on 11 Feb through till 2.00am on 12 Feb and then resumed work at 6:45am to finish at 2:30pm on 12 February. This meant that this staff member had only had 4.75 hours sleep over the course of 24 hours on duty. This placed an additional pressure on staff working when tired. This had the potential to put people at risk of harm.

The medicines administration system was unsafe. We checked the medicine records of all 13 people living at Chy Byghan. We found multiple incidents where medicines had been administered but not signed by staff as given. We also found one incident where a medicine had been signed as administered but was still in stock. We saw medicines audits conducted over the last six months that recorded two queries about whether a person's Warfarin medication had been administered. This had not been followed up with medical professionals. Records stated it was 'unclear' if the medication had been given. There were no records of any follow-up discussions with staff or attempts to obtain medical advice putting the person at risk. The provider had also not ensured there was enough stock of one medicine to be administered. This had the potential to put people at risk of harm.

There was no care plan or risk assessments in place for a person who had moved into the service in January 2018. From a review of the person's hospital health assessment we saw the person had serious health concerns that had not been appropriately assessed or planned for, during their stay at Chy Byghan. Plans to ensure people who required repositioning to protect their skin were not consistently followed. These issues had the potential to put people at risk of harm.

The sluice room which contained chemicals hazardous to health was unlocked. We were told it could not be locked because the key had been lost. The boiler cupboard was similarly required to be kept locked to keep people safe but was open because the key was lost. The cupboard holding the service's electrical circuitry had a sign stating 'keep locked' and 'high voltage' and we found this too was unlocked. Staff found the key for this and locked it when the need for it to be locked was pointed out.

There were inadequate governance arrangements in place to monitor and assure the quality of the service. Staff felt the provider was not addressing the serious issues facing the service.

The provider told us the financial viability of the service was in serious doubt. The question of the financial viability of the service put people who lived at Chy Byghan at risk of not receiving the care service they require.

The overall rating for this provider is now 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Services placed in special measures will be inspected again within six months.
• The service will be kept under review and if needed could be escalated to urgent enforcement action.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. The breach of Regulation 12, Safe Care and Treatment, had continued since the previous inspection in March 2017. The CQC has imposed Conditions on the Registration of the service in light of the risks to people using the service.

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.

The system for managing and administering medicines was unsafe with multiple issues identified regarding ensuring appropriate stock control, recording errors and failure to act appropriately when medicines issues were identified.

There was insufficient staff available to meet people's needs. The number of staff employed by the service had fallen to a low level.

We had concerns about the safety of the fire protection system. The service did not have a fire safety risk assessment in place.

There were ongoing issues with the safe running of the electrical system. There was a fault with the heating and hot water boiler. The boiler fault meant that a number of rooms were not being heated by the radiators served by the boiler and the supply of hot water was inadequate.

Is the service well-led?

Inadequate

The service was not well led. The provider had not ensured safe and appropriate maintenance checks had been made and acted regarding the electrical system and gas heating boiler system.

There were inadequate governance arrangements in place to monitor and assure the quality of the service. Staff felt the provider was not addressing the serious issues facing the service.

The provider told us the financial viability of the service was in doubt. The question of the financial viability of the service puts people who live at Chy Byghan at risk of not receiving the care service they require.

Chy Byghan

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.

The unannounced inspection took place on 12 February 2018. The inspection was carried out by one adult social care inspector. The inspection was prompted by information of concern received regarding the safety of the fire system and staffing levels at the service.

Before the inspection we reviewed the information we held about the service. This included past reports and notifications. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with six people who used the service, the provider, service manager and three staff members. We also spoke with one healthcare professional familiar with the service.

We looked at three records relating to the care of individuals including medicine records for 13 people, staff records and records relating to the running of the service including audits.

Following the inspection we spoke with commissioners, Local Authority Quality Assurance managers and two representatives off the Fire Authority.

Inadequate

Is the service safe?

Our findings

The provider had not assessed the risks to the health and safety of all service users using the service and had not done all that was reasonably practicable to mitigate risks affecting people. For example, there were no risk assessments or care plan in place for a person who had moved into Chy Byghan in January 2018. The person had serious health needs including Type 2 Diabetes and no dietary provision, specifically for this condition, had been made even though the healthcare transfer information had stated a 'diabetic diet' should be encouraged. We spoke with the cook about how specialist diets were provided. They did not know thatany one at the service currently required a diabetic diet. This person had a pressure ulcer clinically assessed as being grade 3.The district nursing team had requested that the person have two hourly repositioning to avoid further skin damage. We reviewed the skin bundle records [a resource pack to aid in the assessment and care planning for people at risk of pressure ulcers]for the person. This showed that the requested repositioning was not consistently being recorded. Staff told us repositioning of people throughout the night was not taking place because there was only one staff member on shift. This meant the service was not consistently able to follow the direction of healthcare professionals to support repositioning throughout the night and therefore the risk of further skin damage was probable.

The provider had not ensured that the premises used to provide care to people living there were safe for the intended purpose. We had concerns with the safety of the fire protection system and saw there was no current fire risk assessment in place for the service. A Fire Safety audit carried out on 9 February 2018 had also highlighted fire safety concerns. For example, the fire protection system was not currently operating as designed. The provider told us a heat sensor had been disabled by an electrician in November 2017 because it was defective and this had not been replaced. We found issues with the safe running of the electrical system. The electrical system was repeatedly 'tripping off' and cutting the power supply. There was a 'high loading' on the electrical system due to the use of four electrical heaters. When the electricity supply was cut off the pressure relieving air mattresses used by one person deflated putting people's skin integrity at risk and where people were dependent on electrical heaters, these were not available to provide heating during these periods. This inspection took place in February when heating would be essential to maintain a comfortable environment. Following the inspection we received correspondence from the provider stating that a certified electrician would visit the service to replace the defective heat sensor. However we have not received documentation as requested to show that this has been carried out.

A fire door on a person's room on the ground floor was kept open with a wooden wedge. The person who used this room required the use of oxygen dispensed from a cylinder. Oxygen is a highly flammable gas. The failure to keep the fire door shut when oxygen was being used posed a fire risk to all those using the service. Staff told us there were faults with at least three of the fire doors at the service which would not close fully, and we were told no fire door was currently fitted with a self-closing mechanism to ensure the door closed automatically in the event of the fire alarm sounding.

We saw that one person's fire exit from their room had been blocked off and taken out of operation. This meant the person could not safely evacuate under the present evacuation plan. Building works had been carried out between part of the kitchen and the providers living area. The work had been left uncompleted

leaving many holes in the block work. A report from the Fire Service audit stated the provider had stated building regulations had not been complied with in undertaking these structural alterations. A report regarding this was sent to Building Control by the Fire Authority. This meant the provider had no assurance of the safety of the unregulated and unfinished building work that had been carried out adjoining the care home.

We had concerns about the provision of adequate heating to people living at Chy Byghan and the risk this caused to people of becoming cold. The provider told us there was a fault with the heating and hot water boiler. The boiler fault meant that three bedrooms and the lounge were not being heated by the radiators served by the boiler. The current heating arrangements, which were through the use of portable electric heaters in the rooms which were not being heated by the central heating system, were not always sufficient to keep these rooms at an adequate ambient temperature. The lounge particularly did not have adequate heating from the available electric heater.

Due to the faults with the boiler we were told that nine rooms including two bedrooms upstairs did not have a supply of hot water. This meant staff had to carry hot water upstairs in order to provide personal care to a person who was cared for in bed and was very frail. The hot water available across the rest of the service was checked and found to be only available at a tepid temperature. Maintenance records evidenced that the gas boiler had not received an annual service since June 2016 and the boiler faults had not been repaired. This meant that service users did not have an adequate supply of safely delivered hot water in order to meet their needs. Following the inspection we received correspondence from the provider that the maintenance issues with the boiler would be checked by a certified plumber on 15 February 2018. However we have not received documentation as requested to show that this has been carried out.

We had concerns about current and future appropriate staffing levels for the service. The provider told us instability in the staff group had been due to uncertainty about the financial security of the service. This had led to one-third of the core staff group resigning. Therefore the provider was heavily reliant on agency staff to cover the rota and meet peoples' needs. On the day of inspection the service was already one staff member short of the three staff members usually allocated to cover the morning shift from 8:00am to 2:30pm. We saw that one of the remaining two staff had to leave the service for one hour and forty-five minutes, leaving only one staff member available to provide care and support for 13 people. Staff told us they did not consider the service to be safe because of the current level of staff absence and uncertainty about the future of the service.

Overnight staffing cover for the service is normally limited to one staff member. The rota showed that overnight staffing had to be planned to be shared by two staff members, with one staff member working part of the night and another staff member taking over to cover the remainder of the night on seven occasions between 12 February and 14 March 2018. Staff told us these shifts were required to be shared because staff responsible for care overnight were also required for day shifts and so could not cover the entire night shift if they were to have enough sleep to work the following day. We saw that one staff member worked from 2:00pm on 11 Feb through till 2.00am on 12 Feb and then resumed work at 6:45am to finish at 2:30pm on 12 February. This meant that this staff member had only had only 4.75 hours sleep over the course of 24 hours on duty. This placed an additional pressure on staff working when tired because they had worked at least part of a night shift. This had the potential to put people at risk.

The medicines administration system was unsafe. We checked medicine records for all 13 people living at Chy Byghan. We found multiple incidents where medicines had been administered but not signed by staff as given. We also found one incident where a medicine had been signed as administered but was still in stock. We saw medicines audits conducted over the last six months that recorded two queries about whether a

person's Warfarin medication had been administered. This had not been addressed with medical professionals. Records stated it was 'unclear' if the medication had been given. There were no records of any follow-up discussions with staff or attempts to obtain medical advice. The provider had not ensured there was enough stock of one medicine to be administered. A record that eye drops needed to be reordered had not been made in a timely manner.

The sluice room which contained chemicals hazardous to health was unlocked. We were told it could not be locked because the key had been lost. The boiler cupboard was similarly required to be kept locked to keep people safe but was open because the key was lost. The cupboard holding the service's electrical circuitry had a sign stating 'keep locked' and 'high voltage' and we found this too was unlocked. Staff found the key for this and locked it when the need for it to be locked was pointed out to them.

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

Inadequate

Is the service well-led?

Our findings

At the March 2017 inspection we found that the service was not well led. Issues identified at the last inspection included a failure in quality assurance systems to highlight areas of the running of the service that required improvement.

The 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. 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. The service did not have a registered manager in post. The registered manager had resigned in November 2017. The provider employed an acting manager to work in the service to cover this role, with the intention that the manager would register as the registered manager once they had obtained suitable qualification and developed enough experience. This had not yet occurred.

During this inspection we had serious concerns about the governance, leadership and culture of the service. The provider had not taken appropriate action to ensure issues identified with the fire protection and electrical systems had been dealt with in a timely manner. This meant there was inadequate heating or hot water in parts of the building. This meant the provider had not ensured that the premises used by the service was safe to be used for the intended purpose, or was being used in a safe way.

We had concerns with the safety of the fire protection system that was not currently operating as designed. This put people, staff and visitors at risk of harm. This meant the person could not safely evacuate under the present evacuation plan.

We found issues with the safe running of the electrical system. The electrical system is repeatedly 'tripping off' and cutting the power supply. The power failures put people at risk, which included to their tissue viability and to keep warm.This meant people were at serious risk of harm.

The fault with the heating and hot water boiler outlined in the Safe domain of this report meant that three bedrooms and the lounge were currently not being heated by the radiators powered by the boiler. The current heating arrangements to het these rooms were not adequate.

Nine rooms including two bedrooms upstairs did not have a supply of hot water. This meant staff had to carry hot water upstairs. The hot water available across the rest of the service was checked and found to be only available at a tepid temperature. This meant that service users did not have an adequate supply of safely delivered hot water in order to meet their needs.

The medicines administration system was unsafe. This included multiple recording omissions on Medicine Administration Records (MAR), inaccurate stock records, fiaulure to order adequate stocks, and failure to request medical advice when medication administration errors may have taken place. These failures had put people at risk.

Current and future appropriate staffing levels for the service had not been secured by the provider. The provider told us there was instability in the staff group due to uncertainty about the financial security of the service. This had led to one-third of the core staff group resigning. The provider was heavily reliant on agency staff to cover the rota. However, we saw that even with agency staff use, there remained five shifts that currently had no staff identified to carry out these shifts. The lack of appropriate numbers of staff will put the service users at risk of harm.

While the staff culture of the service was essentially caring it was not open or transparent. Staff had not been kept informed of what was going on at the service and this had led to speculation amongst staff about the future of the service. As a result one-third of the core staff team had resigned. Staff told us they were 'demoralised' and did not feel supported, respected or valued Many of the staff who worked at Chy Byghan had been there for a period of years and it was clear from our conversations with them that they cared passionately about the people who lived there. Staff were visibly upset by the current uncertain future of the service. We were told, "It's very very sad. The owner is in complete denial about what needs to be done. I don't think it's safe anymore." Another staff member told us they were not kept informed of what was going on in terms of the viability of the service to continue and a third staff member commented that they had been left with 'no choice other than to resign because of concerns about whether they would be paid at the end of the month.

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

The provider told us that the financial viability of the service had become critical, but they were trying to find ways to continue the service. The question of the financial viability of the service puts people at risk of not receiving the care service they require.

This was a breach of Regulation 13 of the Care Quality Commission (Registration) Regulations 2009.

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 13 Registration Regulations 2009 Financial position except health service bodies and local authorities The provider told the Commission during the inspection that the financial viability of the service was in doubt. The question of the financial viability of the service puts service users at risk of not receiving the care service they require.

The enforcement action we took:

Imposition of urgent conditions under section 31 of the Health and Social Care Act 2008.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There provider had not assessed the risks to the health and safety of all service users using the service and had not done all that was reasonably practicable to mitigate such risks. The provider had not ensured that the premises used by the service was safe to be used for the intended purpose and was being used in a safe way. Medicines management systems were unsafe.

The enforcement action we took:

Imposition of urgent conditions under section 31 of the Health and Social Care Act 2008.

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 assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.

The provider had not maintained securely and accurately a contemporaneous record in respect of each service user, incluing a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

The enforcement action we took:

Imposition of urgent conditions under section 31 of the Health and Social Care Act 2008.