HC-One Limited

Chorlton Place Nursing Home

Inspection report

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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
Chorlton Place Nursing Home (known as Chorlton Place) is a nursing home providing personal and nursing care to 43 people aged 65 and over at the time of the inspection. The service can support up to 48 people.

Chorlton Place is a large purpose-built home, with all bedrooms having an en-suite toilet. The ground floor is a residential floor for people living with dementia and the first floor supports people who need nursing care.

People's experience of using this service and what we found
The risks people may face were assessed, however the guidance for managing these risks was not always consistent throughout a person's care plan. People had received their medicines as prescribed; however, staff were not confident using the new electronic medicines system. Guidance was not always clear as to when people required medicines not routinely administered.

There were insufficient care staff at night on the nursing floor. The new manager had requested an additional twilight shift (8pm to 2am) to be introduced. Staff were busy during the day but were able to meet people's needs.

Staff and relatives were positive about the new manager and said communication within the team and with relatives had improved. Staff training had increased and individual staff supervisions meetings were being arranged.

A quality assurance system was in place, with a system of weekly and monthly clinical checks and audits being completed. An action plan was in place for any issues identified in the audits. However, issues with risk assessments and staff guidance had not been addressed since our last inspection in November 2019.

The home was clean throughout and had robust cleaning schedules in place. Staff had received training in the use of personal protective equipment (PPE) and the new manager addressed any concerns if staff did not follow the PPE guidelines.

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 requires improvement (published 10 January 2020).

Why we inspected
We received concerns in relation to the night staff on the nursing unit not meeting people's needs and not accurately recording the support provided. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at 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.

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 coronavirus and other infection outbreaks effectively.

The overall rating for the service has remained the same. This is based on the findings at this inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Chorlton Place Nursing 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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the inconsistent guidance to manage assessed risks, the new electronic medicines system, the lack of clear guidance for medicines not routinely administered and the lack of staff at night on the nursing floor 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 for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Chorlton Place Nursing Home

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 Care Act 2014.

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

Inspection team
The inspection was carried out by two inspectors. An Expert by Experience made telephone calls to gather feedback from relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Chorlton Place is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a new manager who was in the process of registering with the Care Quality Commission. 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.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service about their experience of the care provided. We spoke with ten members of staff including the new manager, nurse, senior care workers, care workers the chef and the area quality director. We observed the interactions and support provided throughout our inspection.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including quality assurance audits, policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. The Expert by Experience spoke with eight relatives by telephone about their experience of the care provided at Chorlton Place.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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

● Risks were not always safely managed. The risks people may face had been assessed and guidance provided for care staff to manage these known risks. However, the guidance was not always clearly recorded and was not consistent throughout the care plan. For example, on the residential floor one person's safe handling assessment stated a slide sheet was to be used with two staff for re-positioning in bed to reduce the risk of pressure sores. However, the skin integrity care plan stated the person was able to re-position themselves in bed and did not need staff support.

● On the nursing floor one person's risk assessment for choking stated they were at low risk; however, their needs had changed, and the risk assessment and guidance had not been updated. The person now required a smooth puree diet, which was noted in a short review section. The risk assessment should have been re-written to clearly identified the change in the identified choking risks. The provider sent an updated diet plan for this person following the inspection and stated the chef had been made aware of their change in needs at the time of the re-assessment. Staff we spoke with were aware of people's eating and drinking abilities.

● The manager told us a new risk assessment / care plan format was being introduced by the provider. These were in the process of being written at Chorlton Place.

● Personal emergency evacuation plans (PEEPs) did not always accurately describe how people should be evacuated safely. One PEEP stated the evac mattress was to be used but there were no further instructions for staff, for example, how the person was to be transferred to the evac mattress.

● Staff we spoke with were able to describe the support people needed. The new manager was aware that the care plan guidance was of variable quality across the home. However, this was the same issue as at our last inspection in November 2019, meaning the plan at that time to review and re-write all risk assessments and guidance had not been successfully implemented.

● Daily record sheets showed people were not always re-positioned in line with their care plans. At the time of our inspection no one living at Chorlton Place had any pressure area sores.

The continued inconsistencies in the risk assessments and support guidance was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Equipment was serviced, checked and maintained in line with regulations and manufacturer's instructions.

Staffing and recruitment

● Our observations of the night staffing on the nursing floor showed there were not enough staff on duty to

meet people's needs. There were two members of care staff and one nurse on duty at night. People on the nursing unit needed two members of care staff for their support. The staff were very busy and were unable to respond to people's care needs in a timely way.

● Staffing during the day was sufficient to meet people's needs, although staff were visibly busy. Care staff told us the nurses did not get involved in supporting people with their personal care, which put additional pressure on the care staff. However, the nurses had to administer medicines and update care plans.

● Two people on the nursing floor we spoke with said the staff were busy and they had to wait for support. One person said they had to go to bed and get up when they are told to as that was when the staff were available to support them. Another person had to wait for night staff to attend to their personal care and was embarrassed they had been incontinent.

● The new manager had requested an additional member of care staff for the nursing unit to work a twilight shift between 8pm and 2am. They were waiting for agreement for this to be implemented. However, this issue pre-dated the appointment of the new manager and had not been actioned by the provider earlier.

The lack of sufficient staff on duty at night on the nursing floor was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Staff were safely recruited, with pre-employment checks being completed prior to the member of staff starting work.

Using medicines safely

● The home had changed to an electronic medicines administration recording system (eMAR) on the first day of our inspection. The system was not fully working on the first floor. Following the inspection evidence was provided showing the internet connectivity was working at the home and the issues had been down to 'user error'. The nurse had video conference support and had administered the night-time medicines from the information on printed paper MARs. They were being supported by a colleague to update the electronic MARs.

● There were similar connectivity issues on the second day of our inspection. This indicated the system had not been robustly tested by the provider to ensure there was sufficient internet connectivity to use the new system. The manager and area quality director said they had raised this issue with the provider's central building department who were looking into providing boosters for the internet signal on the nursing floor. Following the inspection we were told the issues had been down to 'user error' rather than connectivity issues and the system was now working.

● The nurses we spoke with were not confident in using the new system. A senior on the residential unit was more confident, however had not correctly recorded all the medicines administered on their first use of the system. This was quickly rectified. Staff had received training on using the system through video conferencing and had been taken through the system step by step. The first day of our inspection was the first day the new eMAR system was being used; however, the nurses we observed had difficulties with the system when it went live. Further training on using the eMAR system was planned for all staff administering medicines.

● Staff were not able to access the guidance for medicines prescribed 'when required' on the new electronic system. The manager assured us that the original paper copies of the guidance would be made available in the interim. The paper and eMAR guidance were the same information and were not always clear how the person would indicate either verbally or non-verbally if they needed the medicine administered.

● Topical cream charts were completed by care staff when they had applied the cream. Body maps were used to show where the creams were to be applied. However, the guidance was not always clear when the cream was to be used, for example one person's topical cream chart stated to use as required.

Staff not being confident and being able to competently use the new electronic medicines system and lack of clear guidance for 'as required' medicines and topical creams was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Previous paper MARs showed people received their medicines as prescribed.

Preventing and controlling infection
● The home was visibly clean and regular deep cleans of all rooms was completed. Staff had completed training in infection control and been given information about COVID-19.
● Personal protective equipment (PPE) was readily available and staff were aware of what PPE they needed to use. The manager told us staff had to put their mask on as they entered the building, so they were not walking through the home without one at the start of their shifts.
● However, we observed two night staff with lowered masks that did not cover their nose or mouth. We discussed this with the manager, who said they would complete a supervision meeting with the members of staff. We saw they had done this before where they had observed staff not wearing their PPE correctly.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Staff were aware of signs that may indicate abusive practices maybe occurring. Staff received training in safeguarding vulnerable adults and felt confident to raise any concerns with the registered manager.
● Relatives thought their relatives were safe living at Chorlton Place. One said, ""I am happy that [name] on the whole is safe, there have been no accidents and they phone us up straightaway if they need to."
● Incidents and accidents were recorded and reviewed by the manager. Where applicable actions were taken to reduce the risk of a re-occurrence.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider had a quality assurance system in place which included a series of audits, weekly clinical checks and reviews of accidents and incidents. An action plan was written for any shortfalls identified. A home improvement plan was used to collate all actions from the audits.
- The new manager was aware of the issues we found with people's risk assessments and care plans. A template care plan had been written for the nurses and seniors to use as a guide. However, these issues had been identified by the home prior to our last inspection in November 2019. The provider had not ensured actions identified at that inspection had been implemented and embedded at the service.
- Nurses were not confident in how to use the electronic MARs system and how to access information about 'as required' medicines from the system.

The ongoing issues with risk assessments, the associated staff guidance to manage these identified risks and the problems with the introduction of the electronic medicines system were a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others

- The new manager had been in post for two weeks. Prior to this they had been the deputy manager since October 2020. The staff we spoke with were positive about the changes made by the new manager since they had started. One member of staff said, "I now get more support, she's very approachable" and another told us, "Her communication is very good; she'll sort out any conflict and is just the sort of person we need in here."
- Staff training had increased since the manager had started at Chorlton Place. The manager had started to complete staff supervisions.
- Relatives said they were contacted by telephone if there were any changes in their relative's care plans.
- The service had adapted how it worked with other professionals during the COVID-19 pandemic. The GP visited the home three times each week to review people's health and wellbeing. District nurses also visited the residential floor daily. Video conferencing was also used for appointments where possible.

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

● The provider had completed a relative survey in October 2020. The results were generally positive. The provider had written a response to the survey results outlining what changes the service would make following the survey.
● Relatives we spoke with were also positive about improvements in the communication with the home since the manager had started. However, they had also experienced problems with the phone system at the home – either not being able to get through to the home or being cut off when transferred to a different phone. The manager said this was being looked at along with the internet connectivity. One relative said, "The communications were bad, it was the only problem; they have improved with the new manager though" and "It is annoying, we get cut off so often when we phone up, they seem to lose the call when they are transferring the call upstairs."
● Nurse and senior care staff meetings had been held. Care staff told us they were able to raise any issues or comments directly with the new manager if they needed to. They said these were acted upon.
● A key worker system was being introduced at the home. This would provide a named member of care staff to contact families to provide regular updates on their relative's wellbeing.
● The initial assessment process for people moving to Chorlton Place had also changed. Information would be gathered from the current care provider or hospital. The manager would speak with the person and their family (where appropriate) to establish their initial care and support needs. The care plans would be developed further as the person settled into the home and the staff team got to know them better.

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
●The provider and manager notified the CQC and safeguarding teams of any accidents and incidents as appropriate.
● Any complaints made were investigated and formally responded to as per the providers complaints policy.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Guidance for managing identified risks was not consistent across the whole care plan. This issue had not been addressed since the previous inspection in November 2019. Problems with connectivity for the new electronic medicines system had not been sorted out prior to implementation. Nurses and seniors were not able to access PRN medicines guidance and were not confident using the new system.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff at night on the nursing floor to meet people's needs.