Irvine Care Limited

Chiltern Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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 13, 14 and 15 February 2017. During the previous inspection in October 2015 we had concerns about the lack of support staff were receiving through training and supervision. We reported on a breach of Regulation 18 HSCA (RA) Regulations 2014. We found in this inspection there had been improvements in this area, but further developments were now necessary.

Chiltern Court Care Home is a registered nursing and residential home. It is registered to accommodate and care for up to 53 older people. At the time of the inspection they were providing care for 33 older people.

The home is required to have a registered manager in place. 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.

At the time of our inspection the registered manager was absent due to sickness, they had resigned from their post the week prior to our inspection, they were not returning to the service. As a result, the regional manager was covering for the registered manager until such time as a permanent or interim manager is employed.

During our previous inspection in October 2015 we had concerns the provider was not supporting staff with adequate training and supervision. We found during this inspection that this had improved, however we identified new areas that staff needed support and training in such as respect and dignity and skin care.

Medicines were not administered and recorded safely. Audits of medicines had not been completed accurately. There were inaccuracies in the records of the amount of medicines in stock. This placed people at risk of not receiving their medicines in a safe and appropriate way.

Systems used for the recruitment of staff were not robust. Gaps in applicant's previous employment histories were not checked. This meant the provider could not be sure they were employing staff who were safe to work with people.

Although staff were knowledgeable about the process of identifying and reporting concerns of abuse, we found this process was not followed through by the registered manager. Incidents and concerns had not been reported to the local authority safeguarding team. The registered manager had not followed the multi-agency agreement on reporting safeguarding concerns. Notifications regarding incidents had not been sent to the Care Quality Commission (CQC). This placed people at risk of harm.

We were told there were sufficient numbers of staff working in the home to meet people's needs. We found at various times, staff were not visible. The deployment of staff had not taken into account the fact that staff took breaks at the same time, leaving a lack of staff presence in the home. We have made a

recommendation about the staffing.

Health and safety checks had been carried out regularly, and policies and procedures were in place to ensure sufficient checks were made on the premises and equipment to keep people safe.

We had concerns about the support offered to people to eat their meals, this was not adequate as the positioning of some people placed them at risk of choking and made eating difficult. Where people required support and encouragement to eat food this was not always evident. Records related to the intake of food and fluids had not always been completed accurately.

Not all staff were aware of how to apply the Mental Capacity Act 2005 to their role. One person was being un necessarily restricted, although the regional manager had intervened to stop this practice, as the person had the capacity to make their own decisions. We have recommended the service looks at training for staff in this area.

Staff did not always show respect to people or protect their privacy and dignity. Staff did not always knock on people's doors or ask permission before entering. Staff were not always aware of the needs of people and therefore people were placed at risk of receiving inappropriate care.
Records did not demonstrate staff were carrying out the care people needed at the time they needed it. People complained they were not being washed regularly. One person told us their skin was sore because they were not being assisted to wash properly or regularly.

Although activities were provided in the home, these were not sufficient to protect people from the risk of social isolation and insufficient stimulation. People told us they were "bored", and we saw very little in the way of activities for people.

People told us they did not know how to make a complaint. We saw documentation related to two complaints, but no information to demonstrate how they had been dealt with, and if any learning had taken place. We have made a recommendation about updating the practice of dealing with complaints.

Overall, we had found the home had not been well led. Standards had dropped since the previous inspection in October 2015. It was not evident the registered manager had monitored the day to day culture or the provision of care throughout the home. Information they had passed to the regional manager regarding the quality of care did not reflect what we found during our inspection. Positive feedback was given to us regarding the skills and knowledge of the interim deputy manager and the regional manager, and we were reassured by their presence in the home. They showed a commitment to improving the standards of care at Chiltern Court Care Home.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.You can see what action we told the provider to take at the back of the full version of the report

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?

Inadequate

The service was not safe.

People were placed a risk of harm because we found errors in the recording and administration of medicines. Audits did not accurately reflect our findings.

People were not safeguarded against the risk of harm or abuse, as the registered manager had failed to record incidents and inform the relevant organisations.

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

Is the service effective?

Requires Improvement

The service was not 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. This placed people at risk of having their liberty unlawfully deprived.

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 caring.

Staff did not demonstrate how to protect people's privacy and dignity. Staff did not always show respect to people or each other. This meant people's rights were not always considered in the provision of care.

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

Staff demonstrated a genuine fondness for the people they were caring for, however this was not always balanced by staff having

the correct skills and expertise. This did not demonstrate care was provided in a person centred way.

Is the service responsive?

Requires Improvement

The service was not responsive.

Pre admission assessments had not always been completed in sufficient detail to ensure the plan of care would be accurate. This placed people at risk of receiving inappropriate and inconsistent care.

People's care did not always meet the expected standard. Records related to the application of creams and the carrying out of personal care were not detailed. This did not demonstrate care was provided in a consistent way that met individual people's needs.

A lack of activities throughout the home left people "bored". Although the activity coordinator tried to facilitate activities, people were still left at the risk of social isolation.

Is the service well-led?

Requires Improvement

The service was not well led.

The registered manager had failed to carry out their role effectively. Documents were not available, and records related to the running of the home did not evidence they had followed the correct procedures. This placed both people and staff at risk of harm.

Records and care practices had not been monitored. There had been a lack of oversight of the culture of the home. This meant that improvements had not been identified or implemented.

Information sharing had not taken place between the home and outside organisations and with their own provider. The registered manager had failed to provide a transparent and open culture that encouraged the growth and development of the service.

Chiltern Court 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 was planned to check 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 13, 14 and 15 February 2017and was unannounced. This meant the service did not know we were coming.

The inspection was carried out by one inspector. Before the inspection, we asked 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. This was returned to us. We reviewed previous inspection reports and other information we held about the service including notifications. Notifications are changes or events that occur at the service which the provider has a legal duty to inform us about.

We spoke with six people who lived in the home, one relative two health professionals and a social worker. We also spoke with 10 staff including the regional manager, the resident experience care specialist, the assistant chef, nurses, and care staff. We reviewed five people's care plans and nine people's medicines records and records related to the running of the service.

Inadequate

Is the service safe?

Our findings

Four out of the five people we spoke with told us they felt safe living in the home. Their comments included "The atmosphere makes me feel safe, I feel like I am being looked after." "I trust the people that are looking after me. If a staff member turns up who I haven't met before I ask them who they are before I let them in." One person told us they did not feel safe at nights due to the noises they heard.

Where people required assistance with medicines these were administered by trained staff. We observed a nurse administering medicines to people. They ensured people were told what medicines they were being given and for what reason. When speaking to people we observed the nurse got down to the person's level so they could make eye contact with them.

Medicines were stored securely, and only appropriately trained staff had access to them. We found the storage area had limited space and it made it difficult for staff to access the medicines cupboards in situ, however when being used to administer medicines, the trolleys were removed from the room to people's rooms.

We undertook checks to ensure the storage, administration and records related to medicines were safe. Controlled drugs were stored in a secure locker and records were kept up to date in a controlled drug register. The Medication Administration Record (MAR) charts were up to date, properly maintained, were easy to follow but were only partly completed. This was because the application of prescribed creams and lotions were recorded separately, and kept in people's rooms. The creams and lotions were applied to people by care staff. Staff told us and records verified staff had not received any training in how to administer creams and lotions. We found gaps in the documents related to the application of creams. This meant it was unclear if the creams and ointments had been applied and if they had been applied correctly.

One person told us their skin was "sore" and they felt their skin was "burning". Photographs showed which areas were sore and red. We were told this was a result of incontinence. Records showed there were significant gaps in the dates that the person had their barrier cream applied. We spoke to the nurse on duty about the gaps in this person's records and the lack of their medicated cream being applied. They told us they had run out of the cream for this person. The Resident Experience Care Specialist (RECS) was alerted and they undertook further investigations into the person's health, later that day this person was admitted to hospital. The RECS showed us they had plans in place for training staff in skin care to ensure staff were clear about their responsibility.

We checked the stock of as required medicines against the recorded amounts that had been administered. We found discrepancies between the recorded amounts of stock against the actually stock held. For example, for one person it was recorded there should have been ten tablets in stock when actually there were 32. We looked at the records for another two people and found it was impossible to check how many tablets had been administered or how many should be in stock as the amounts recorded were not clear and did not add up.

The system used for the safe ordering of medication was not robust. During the inspection we spoke with the GP. They told us how the home had requested a prescription for creams for two people only four days after a previous prescription had been issued. Instead of monthly repeat prescriptions being requested, ad hoc prescriptions were requested for medicines. For example, tablets for a few days or for a week. It was not clear why this was happening. .

We were told medicine audits had been completed by the registered manager; however the issues we found had not been highlighted to the regional manager through the audit system. This meant the information in the audits was not reliable.

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

Staff were aware of their roles and responsibilities when identifying and raising concerns about safeguarding people. The staff felt confident to report concerns to the registered manager. Procedures for staff to follow with contact information for the local authority safeguarding team were available. Staff were able to identify signs of abuse and knew how to report them. Prior to the inspection we were made aware by the local authority of four safeguarding concerns which related to the welfare of people who were living or had lived in the home during the previous 12 months. At the time of the inspection the regional manager could not find all the documentation related to the safeguarding concerns, only some of the information had been recorded on the incident reporting system. It was not identified as a safeguarding concern. .The process for recording safeguarding concerns had not been completed by the registered manager. The registered manager had not informed the Care Quality Commission (CQC) of the concerns. The regional manager had not been made aware of some of these safeguarding concerns. During the inspection we were made aware of two more concerns which related to the conduct of staff. We brought this to the attention of the regional manager. They told us they would investigate what action had been taken and if these concerns had been reported to the local safeguarding team. This meant people were not protected from the risk of abuse as the process for reporting and documenting concerns was not robust. The lack of information shared meant there was not an open and transparent culture in relation to the sharing of information with the necessary organisation in relation to concerns of abuse.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The systems in place for the safe recruitment of staff had not been followed. We looked at the recruitment records of three staff employed at the home. Recruitment records contained the relevant checks including a Disclosure and Barring Service (DBS) check. A DBS check allows employers to check whether the applicant has any past convictions that may prevent them from working with people. References were obtained from previous employers as part of the process to ensure staff were suitable and of good character. However, we found gaps in two applicant's previous employment histories. There was no documentation to verify the registered manager had enquired as to why there were gaps in people's employment. The RECS investigated the gaps for one person and gave us a satisfactory explanation. We received assurances from the provider the other person's employment history gaps would be investigated. This had placed people at risk of harm as the registered manager had not taken necessary action to ensure staff were of good character and safe to work with people.

During the inspection we observed most people living in the home were cared for in bed. On the first day of the inspection we saw only one person was out of bed. On the third day there were five people out of bed. People had alarm bells in their rooms. For one person this was not connected, as there was a risk of them

damaging themselves on the cord. Staff completed hourly checks to ensure they were safe. We found one call bell did not work. Following the inspection the regional manager told us the bell did work but sometimes came out of the wall socket. They were looking at alternative cables to prevent this from happening. All staff had been reminded to include checking the bells in their routine checks. We were with people on three occasions when they needed assistance or we pressed their call bell. On the first occasion it took four minutes for staff to attend, on the second occasion we found the bell did not work, on the third occasion it took fifteen minutes for staff to respond. We saw in this case a staff member walked past the room twice. We raised this with the regional manager who told us they would look into why this had happened. This meant people who needed assistance were left or were not always able to call for assistance when needed.

The home had a tool to assess the dependency needs of people to ensure the required number of staff were available to meet people's needs. We checked the staffing rotas for the previous four weeks and saw the required staffing levels had been maintained, however this was because agency staff were used to cover staff vacancies. During the inspection we observed at times there was only one staff member available on the ground floor or the first floor .,Other staff were available, but they were carrying out care for people in their bedrooms. This meant people were left who required assistance. We discussed this with the regional manager. They assured us there were enough staff present in the home, however the deployment of staff meant that they were not always in the place they were needed at the time they were needed. We saw staff rest breaks coincided with each other which left a shortage of staff available to support people at Chiltern Court. We waited with one person who tried to find a member of staff to give them their pain relief. We waited for six minutes before a staff member appeared. They were not able to find a nurse so had to go upstairs to find a nurse. The regional manager agreed to look at how staff allocation and rest breaks could be altered to ensure staff were deployed more effectively throughout the home.

We recommend the provider puts systems in place to ensure people using the service are responded to in a timely way when needing support.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. The risk assessments were clear and contained clear guidelines for staff on how to manage the risks. For example, in relation to each person's mobility. Moving and handling risk assessments were in place to ensure any risk of harm to the person or the staff was identified and minimised, through good practice guidelines.

Health and safety checks were carried out. Environmental risk assessments had been completed, so any hazards were identified and the risk to people either removed or reduced. Checks were completed on the environment by external contractors such as the fire system. Certificates of these checks were kept. Fire equipment had been checked at the appropriate intervals and staff had completed both fire training and fire evacuation drills. There were policies and procedures in the event of an emergency and fire evacuation. Each person had an individual evacuation plan to ensure their needs were recorded and could be met in emergencies.

Requires Improvement

Is the service effective?

Our findings

During our last inspection in October 2015 we had concerns the provider was not protecting people against the risks associated with unsafe or unsuitable practice because of inadequate staff training and supervision. We reported on a breach of Regulation 18 HSCA (RA) Regulations 2014. During this inspection we were shown documentation that verified this had improved overall but there were still areas staff needed training and support in.

Following this inspection CQC were sent information from the provider regarding the computer system that recorded when training had been completed by staff. A fault with the system had been identified and as a result the timing of refresher training for some subject areas was wrong. For example, the system stated that training in safeguarding people was required every 10 years, when in fact it was required annually.

On the first day of this inspection in February 2017, we were told the training matrix had not been kept up to date by the registered manager. During the inspection the Resident Experience Care Specialist (RECS) worked on the matrix to update the information. The updated matrix showed that 81% of staff had completed the mandatory training. When the adjustment was made for the system failure, this then showed 71% had completed the mandatory training. Whilst there were still gaps in the training of some staff we were assured this had been identified prior to the inspection, which had resulted in the Resident experience care specialist being present in the home at the time of the inspection. Part of their role was to support the registered manager in maintaining records related to training and to ensure that staff received the correct training in order that they could carry out their roles effectively. This was work in progress at the time of the inspection, and had been included in the action plan given to us before we left the inspection.

Records showed the staff had received supervision regularly and mostly in line with the provider's policy of six times each year. This was an improvement since the last inspection.

Most people living in the home told us their needs were met by well trained staff. One person told us "One or two of the younger ones [carers] have to have a 'trained' carer with them when they do anything. If staff didn't know what to do I feel sure they would get help." Another said "I think the staff are well trained, I am looked after well. That is all I know and all I care about." One person told us they did not think the staff were well trained, because they had concerns about the way their personal care was carried out. We shared their concerns with the regional manager. They told us they would take action to address this.

Staff told us about the training they received. One staff member said, some of the training could be better. They told us due to a lack of training they were not adequately skilled to meet the needs of a person when they moved into the home. This was because the person had a catheter bag. The activities person told us they had not received training in how to provide activities to people. Another staff member told us "I prefer for staff to receive training before they start working with people, that way they get used to good practice and this sticks. Here we do training, e learning and working with people at the same time. I miss the face to face training. When you do this you get the opportunity to ask questions and get answers, this means you have a better understanding." We discussed this feedback with the regional manager, they told us their plan

was to increase the face to face training, for the very reason given by the member of staff. They were aware the activities person had not received training, and were looking into how they could address this. The RECS showed us a training plan which included areas of training that were necessary for the role of carer. They said they were going to implement the training within the home, covering areas such as dignity in care, and skin care.

We recommend the provider seeks advice from a reputable source regarding appropriate training for staff.

We observed people at lunch time over the three days. Most people ate in their bedrooms and a few people ate in the lounge. On the first day we found three people were not properly positioned to facilitate them eating their meal safely or comfortably. Two of the three people were slumped forward in their beds, whilst a third was lying down in bed. This made eating and drinking difficult for people, and placed one person at risk of choking.

One person's care plan stated the person had been reviewed by a dietitian in January 2017 because of concerns regarding weight loss. The person was prescribed nutritional drinks and the advice stated to offer the person fortified puddings between meals and "Continue to encourage oral intake and provide suitable equipment and environment to encourage intake." The person was lying down in bed and their position was slightly elevated at their head and shoulders. Their food had been positioned on the table above their bed and it appeared the person could not see what was on the table above them. On the table was a cooked meal, the person was drinking from a beaker. Because they could not see the meal they placed their beaker back on the table in the middle of their meal. The person was at high risk of choking due to their poor positioning. We pointed this out to the regional manager who arranged for the person to be repositioned. The meal had been left for fifteen minutes and no support had been offered to the person in this time. Throughout the three days we observed the same person in bed with food on their table, but the person was asleep. The food had not been eaten and we observed no encouragement from staff towards the person to eat their meal apart from when we asked one staff member to do so.

Where people's food and fluid intake required monitoring to prevent dehydration and malnutrition, forms were in place for staff to record their intake. However we found that records were not accurate, up to date or complete. For example, one person's records described what they had been offered, but not always what they had consumed. There were gaps in recordings. We were told the nurses monitored the intake of food and fluid, but there was no documentary evidence to support this.

This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they liked the food offered to them in the home. One person said "I am offered more than enough. The food is exceptionally good; it tastes good and is nutritious." Other comments included "The food is good I like it, they give you ample to eat here. We get a choice of meals it is very good." "I would give the food 75%. It could be better, the meat is a bit tough sometimes." One person had restrictions on what food they could eat, they told us "If it is curry they will ask me and do a special lunch for me, because I can't eat curry. The food is nutritious, I have no complaints. Soup and sandwiches I can't cope with, they usually give you these at night, it is a lot to digest, so they usually give me something else." It was clear from what people told us they were satisfied with the choice of food and alternatives were available. We observed the food looked appealing and portion sizes were adequate. We spoke with the kitchen staff and the regional manager about increased training for the catering staff in supporting people with diabetes. This was something the regional manager was looking into. This would help provide a wider variety of food for people living with diabetes, and would ensure their diet was appropriate to their needs.

Care records included information about any special arrangements for meal times and dietary needs of people. Where people had special dietary needs, there was evidence that the information regarding their needs had been communicated to the kitchen. There was a white board in the kitchen highlighting what each individual person required in their food preparation, for example if the person required soft food.

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).

Staff had received training in MCA and DoLS. 74% of all staff had completed the training. Not all the staff we spoke with understood the principles of the act, or were aware of who had a DoLS in place. Without an understanding of this, people's human rights may be compromised. For example, one staff member told us how a person was prevented from leaving the building because they may have come to harm. The staff member failed to recognise the person had the mental capacity to make the decision and understood the consequences of taking such action. To prevent the person from leaving the home would have amounted to an illegal deprivation of the person's liberty. The regional manager told us the person had complained about the staff wanting to protect them, and the regional manager had spoken to staff about the person's right to make their own decisions and choices.

The service had made applications to the local authority for DoLS to be in place for some people, however it was unclear how many had been applied for because the documentation was not centrally stored. We were shown applications for three people however we found another application in a person's care file. One application had been granted. We read how people's capacity had been assessed and how decisions had been made in people's best interest and had involved family representatives and other professionals. As part of the action plan provided to us the need for further training in MCA and DoLS had been recognised by the provider and this was to be carried out with staff in the near future.

We recommend that the service ensures they are working to the requirements of the MCA

Records showed people had access to healthcare professionals when needed. Records showed people attended appointments for hospital appointments, diabetes care and GP appointments. The GP carried out a weekly visit to the home and responded when requested, when people were unwell. This helped to keep people in good health.

Requires Improvement

Is the service caring?

Our findings

There had recently been a new intake of staff, who were new to the home and some were new to caring. Without being intrusive we observed how staff supported people. We noticed that most people were cared for in bed. Most of their bedroom doors were open during the day, these were closed when personal care was being provided. However, we observed staff entering people's rooms without knocking and without asking permission to enter.

Whilst speaking with a person in their room a staff member entered after knocking on their door. The person told us "That is politeness, she knocked on the door, the majority do, if they all did that the place would be different altogether." Whilst speaking with another person in their room they told us staff always knocked on their door before entering. At the same time a member of the cleaning staff entered the room without knocking, they did not speak or acknowledge the person. The staff member went into the person's bathroom and returned again without responding to the person.

We observed a member of staff at lunchtime offer a person an apron to place over their clothes, to prevent spillages from marking their clothes. The person refused, the member of staff ignored the person and placed the apron on them. We could see from the facial expression of the person and their body language they were angry about this. As soon as the staff member had placed the apron on them they ripped it off and threw it on the floor. This did not demonstrate that staff had an understanding of how to protect people's dignity. We were also told by a person living in the home of how their privacy and dignity had been violated by a member of staff. We fed this situation back to the registered manager who was going to make further enquiries. .

One staff member told us staff needed to show more respect for people when speaking about them in corridors, as anyone would be able to hear discussions. This did not demonstrate people were treated with respect and their privacy was not protected. We discussed this with the regional manager who informed us they would review staff training to ensure they understood people's need for dignity and respect.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a genuine sense of fondness between the staff and people. Most people appeared happy and relaxed in staff company. Staff appeared caring and attentive and helped people at their own pace, ensuring they were not rushed. People described the staff as "Gentle." "Friendly" "Kind and understanding." From our observations of the staff they cared about the people living in the home.

Some staff knew people well, whilst others didn't. We asked three staff members at the same time which people on the first floor had a bath or a shower, one staff told us they were not used to working on this floor and therefore didn't know. The other two staff told us they did not know. We asked a staff member about a person who was not well positioned to eat their meal, they told us the person did not like to sit up in bed, they did not acknowledge the risk to the person of lying down when they were eating and drinking. The

person's care plan identified the person needed to be positioned correctly when eating and drinking. We asked a nurse how often one person's dressing needed changing, they told us every other day. However this person's care plan stated it should be every day. This nurse told us they had been off sick and had not updated themselves on reading people's care plans since their return. We saw in one person's care plan that they wore dentures. We asked a carer and a nurse if this person wore dentures. The carer told us the person didn't, the nurse told us they were not sure, but would look for them in their bathroom. We had observed the person for three days without wearing their dentures. The nurse found the dentures. The dentures were unclean and there was no cleaning material to clean them. Although the care plan referred to the person wearing dentures for meals, not all staff were aware of this. This did not demonstrate that staff knew the people they were caring for or their preferences or needs. Care was not centred on people as individuals, and care plans were not always translated into the care provided.

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

People were treated with kindness by staff. We observed how when one person became upset and angry, staff worked with the person to help calm themselves down. The staff were gentle and reassuring and provided appropriate advice to the person to assist them to deal with the problem. We also ascertained that some staff had built important relationships with people. They chatted to people in a way that was meaningful to people. We overheard staff joking and laughing with people. One person had poured a cold drink over themselves, we heard the staff member making light of the situation and minimising the event. We heard the same member of staff in a bedroom with someone, telling the person that whatever they had done or said had made the staff member's day. People and a relative told us staff were "Caring and very pleasant"; "If I have ever asked for anything they [staff] have made every effort to do things for me".

We were told by one person how they had been supported by the interim deputy manager. The person had experience a traumatic experience in hospital, when they came to the home the interim deputy manager spent time with them. They told us "She [interim deputy manager] is ultra-kind. She just said if I needed to talk she would be there for me. She was brilliant. She gave me time to talk it through. She is brilliant, she is a really nice lady." A relative commented on the qualities they had found in the interim deputy manager, they told us "She is very capable and forward thinking. She was the nurse on duty and was very much on the ball." Staff told us "[Interim deputy manager] is approachable and when you talk to her she takes you seriously and she listens to you." This showed that both people and staff felt listened to and their needs were acted upon by the interim deputy manager, who was a role model for other staff.

Where people were able to they were involved in the planning of their care. Documents showed people had given consent to aspects of their care for example the use of bed rails. Where they had not been able to do so, family member's had been involved in decisions about their care as part of the best interest process. People told us they felt listened to and staff responded appropriately. For example one person told us how they chose how and when they did their walking exercise. They said, "If I have to anything even walking round the room, or anything outside of the room, one of the carers takes me in the wheelchair. They have been very supportive and I have never been refused anything."

Requires Improvement

Is the service responsive?

Our findings

During the inspection we spoke with a relative who had concerns about the care their loved one was receiving in the home. The person had been admitted from hospital and was receiving respite care. The concerns were around the lack of care being provided, and poor communication between staff and external professionals. This resulted in confusion over what the person was able to do safely and what they were not. We looked at the pre admission assessment. There was no date on the assessment so we could not verify if the assessment had been completed prior to the admission of the person to Chiltern Court. We looked at other pre admission assessments and found the same lack of recording therefore it could not be confirmed if the assessment had taken place prior to the person moving in. It is important that pre admission assessments are completed prior to people moving into the home, as this is part of the assessment of the person's individual needs and it aids the provider in ascertaining if they are able to meet the needs of the person. The assessments were completed with basic information. The relative told us there was no care plan in place for the first few days after the person entered the home. Without sufficient information the person was placed at risk of receiving inappropriate and inconsistent care.

We discussed the pre assessment of people's needs with staff. One staff member told us the information they received was not always accurate, as the assessment was based on what the assessor was told. They gave us the example that one person had arrived at the home and staff had been told the person could walk, it transpired they could not. They told us the registered manager would take verbal information about the person but did not always see what people could do and what they needed help with.

Each person had a care plan and risk assessments associated with the care being provided. Although the care plans appeared comprehensive and up to date, staff had not always read them and were not up to date with the current needs of some people. Each person's care file was reviewed at least monthly and more frequently if any changes to their health were identified.

Records did not clearly demonstrate staff provided adequate care. Some examples we saw were where records had gaps in them and people told us their care had not been provided as expected. When we checked the records of when the cream had been applied to a person's skin we found gaps in the recordings of up to four days.

Some people told us they had not received a body wash or a bath. One relative told us their loved one had moved into the home and had not received a full body wash for four days, records showed the person had received personal care but did not specify whether this included a body wash. The first recorded full body wash was eight days after the person moved into the home. They told us the person had to ask staff to carry out a full body wash as it was not offered to them. Another person's records showed they had not received a body wash or shower for seven days. A person told us they had not received a regular body wash. They told us as a result their skin had become sore. It was important for them to have good personal hygiene due to the risk of skin infections and developing sores. We looked at the records and read that they had received three full body washes in a 15 day period. We shared our concerns with the regional manager who said they would deal with it. Since the inspection the regional manager told us they requested care staff record in

more detail the care that was being provided to people.

People were supported to participate in activities. There was an activities co coordinator in the home who worked from Monday to Friday. They had not received any training but had asked the registered manager "Quite a long time ago" for training but this had not been forthcoming. They told us they had recently asked the regional manager and they were looking into it. They told us they spent between 10 minutes and half an hour with each person. In a week they would try to see everyone in the home. They were working on collecting people's life histories, so they could gear activities around people's preferences and hobbies.

It was evident to us there was insufficient time for the activities co coordinator to carry out meaningful activities with people regularly. People told us they were bored. One person who was receiving respite care told us they did not have a television in their room. They had a hearing loss and found it difficult to hear the TV in the lounge area. They told us they felt "let down" by the lack of activities. Another person told us "I sit here and think now what." The person had previously had lots of hobbies but whilst living at the home they no longer participated in them. This placed people at risk of a lack of stimulation. One staff member told us "I wish they did more activities. I think we have a lot of clients and a lack of a decent budget. Extra staff would be nice to get people a cup of tea, do their hair and nails. Spending time with them making them feel stimulated." One staff member told us there had been a tea party for the queen's birthday, and there were photographs showing people enjoying entertainment at Christmas. Other activities we were told about included a church service held weekly in the home for those who wanted to attend, and a singer who performed on a Friday. Most people were cared for in their bedrooms, and without stimulation and human contact they were placed at risk of social isolation.

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

People told us they did not know how to make a complaint One person told us "I would just sit here and shout. I would tell the staff." Another said "You can't really complain because they [staff] are busy. I wouldn't know how to complain." One person told us on one occasion their relative complained on their behalf, they were pleased with how the complaint had been resolved and they received an apology. We saw records of two complaints that had been made to the registered manager. However whilst we saw evidence the complaint had been passed to the registered manager we saw no evidence of what happened to the complaint or how it had been dealt with. The home had an electronic system for raising complaints or compliments. An electronic device was made available to all visitors and was located in the foyer of the home. This gave visitors the opportunity to record any concerns. These were sent directly to the registered manager and the regional manager. This enabled them to respond quickly and to rectify the situation immediately if possible.

We recommend that the service consider current guidance on how the provider can improve communication with people regarding the complaints process.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection the regional manager was working at the home covering in the absence of the registered manager. There were mixed responses about the management of the home from people and staff. One person told us they thought the home was well managed because "Everyone is well looked after." Another person told us it was not well managed and felt they needed more staff. Staff told us the registered manager had spent a lot of time in their office. One person told us they never spoke to the registered manager, they only said hello to each other. One staff member described the registered manager as "Militant about the care provided but not tough with staff." They told us the registered manager would walk the floor and offered help and advice to staff. Another staff member told us the registered manager was effective, this was because "They filled the home quickly, but not always with clients we could cope with."

We had been made aware of two concerns about the home in the couple of months prior to the inspection. We had received two safeguarding concerns from the local authority which they were investigating. The law requires registered managers to inform CQC about any safeguarding incidents. They do this by sending us a notification. We had not received any notifications from the registered manager related to safeguarding incidents since December 2015. Between this time and the date of the inspection we were made aware of six safeguarding concerns including two that were disclosed to us during the inspection. In December 2016 we were also informed by a third party that the service did not have access to hot water as there had been a problem with the boiler. The registered manager was requested to send us a notification in relation to this incident, but they failed to do so.

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

Throughout the course of the inspection we found the records related to the provision of care were inadequate, for example, how much food or fluid people had consumed. This did not allow the registered manager to know if people's health was being maintained and to monitor their nutritional needs. Following the inspection the regional manager checked the medicines records, 17 medicines errors had been recorded in February 2017. None had been recorded in the three months prior. Pre admission assessments had not been carried out thoroughly and there was little evidence for some people they had been completed prior to the person's admission to the home. We were told by the regional manager the required audits to identify areas that needed improving had been completed by the registered manager and submitted to them as part of the auditing process. Our findings along with their own were not reflected in the information the regional manager had received. Without accurate audits and monitoring people were placed at risk of harm, as the provider could not mitigate the risks of poor care to people.

We found the staff were willing and keen to develop skills in caring for people, and their attitude towards each other and to the people living in the home and their relatives was on the whole friendly and kind. However, we observed one incident involving a care staff member and nurse. The nurse had asked the care staff to assist with moving a person so that they could take their medicine safely. Initially the care staff member did not respond to their request. When they did respond they were belligerent and argumentative and raised their voice at the nurse. This incident occurred in the corridor in front of us and within ear shot of

the people living in the home. It was not acceptable and not professional. We reported this to the regional manager, and we were told action would be taken with the care staff member. We were concerned how the staff member would behave when they were not being observed and their lack of respect towards senior staff. We were concerned that staff had not been given sufficient skills and knowledge prior to working with people to enable them to be confident they were meeting the required standards of care.

Although the regional manager had been made aware of some of the information related to the safeguarding incidents, they had not been fully informed about all of the incidents. Records were not available to show the registered manager had followed the expected process of referring safeguarding concerns to the local authority. The regional manager shared our concerns about the lack of recording and transparency. The regional manager was speaking directly with the safeguarding team to establish if the procedure had been followed and if any corrective action was needed.

We were told by staff the registered manager spent a lot of time in their office. We were worried they would not have had a clear oversight of the day to day culture of the home if this was the case. This was further reinforced by the poor standards of care practice we observed. This included the poor positioning of people for meals, the lack of dignity and respect shown to people and the concerns related to the lack of personal care in relation to body washes, baths and showers. We were shown evidence of the impact of ineffective personal hygiene and skin treatment for two people which included sore and inflamed skin, which caused the people pain. Following further investigations one person was admitted to hospital. Staff were not knowledgeable in some areas of care provision, for example, restricting one person's access to the outside world. Training was required to ensure staff had the knowledge and skills to carry out the expected standards of care. Without these expertise people were placed at the risk of harm from receiving unsafe and inappropriate care.

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

Staff told us since the regional manager was working at the home things had improved. Comments included "Since a change of managers it has all been pretty good, things are running ok." "[Regional manager] has made good changes. Action wasn't taken as quickly with [registered manager]." We observed how the regional manager made themselves available to staff and people and was seen walking around the home responding to people's requests. Positive comments about the interim deputy manager reassured us the current management in the home would be making the necessary changes to improve the care to people.

Throughout the inspection we communicated directly with the regional manager. They showed concern for our findings, and acted swiftly to correct situations we had highlighted. They were responsive and proactive in establishing the root cause of problems and establishing solutions. For example the lack of staffing had resulted from the poor deployment of staff rather than a shortage. By the end of the inspection they had produced an action plan of the areas we had discussed and they demonstrated a clear intention of improving the care for people. Following the inspection we received further information from them regarding plans for training for staff and systems they were putting in place to ensure the quality of care for people improved quickly.

Following the inspection we spoke with a member of the Local Authority, who had carried out an unannounced visit to the home. They told us the home had stabilised since our inspection. This was due to the actions taken by the regional manager to improve the management of the home and the quality of care provided to people.

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 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of people was not always appropriate, did not always meet people's needs, and reflect their preferences. People were not always provided with activities or social contact to protect them from social isolation. Regulation 9 (1) (2) (3) (a) (b) (c) (d) (e) (f) (g) (h) (I)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify CQC of all incidents that affect the health, safety and welfare of people who use services. Regulation 18 (1) (2) (e) (g)

The enforcement action we took:

We have served a notice of decision to impose positive conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people were treated with dignity and respect at all times by staff. Regulation 10 (1) (2) (a) (b)

The enforcement action we took:

We have served a notice of decision to impose positive conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to maintain the proper and safe management of medicines. Regulation 12 (1) (2) (a) (b) (c) (f) (g)

The enforcement action we took:

We have served a notice of decision to impose positive conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered manager failed to report concerns related to abuse, and in doing so placed people at risk of harm. Regulation 13 (1) (2) (3)

The enforcement action we took:

We have served a notice of decision to impose positive conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider failed to put systems in place to support people with their nutritional and hydration needs. Regulation 14 (1) (2) (a) (b) 4 (d)

The enforcement action we took:

We have served a notice of decision to impose positive conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); Regulation 17 (1) (a) (b) (c) (d) (e) (f)

The enforcement action we took:

We have served a notice of decision to impose positive conditions on the provider's registration.