London Residential Healthcare Limited

Chestnut House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on the, 24, 25 and 31 May 2018 and the first day was unannounced. We last inspected this service in October 2017 where it was rated Inadequate in the safe and well led key questions and 'Requires Improvement' in the Caring, Responsive key questions. This meant the overall rating was inadequate.

Chestnut House is 'care home'. 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.

The service is registered to provide accommodation and residential and nursing care for up to 85 older people over three floors. At the time of our inspection the service was providing residential care to 34 older people some of whom were living with a dementia.

Following our inspection in October 2017 we imposed a condition on their registration. We asked the provider to complete an action plan to show what they would do and by when to improve the key questions Safe, Effective, Caring, Responsive and Well-led to at least a 'good'.

At the inspection in October 2017 we found people were not safe as people did not consistently receive safe care and treatment, audits and quality assurance systems did not always identify shortfalls in the requirements of the regulations being met.

The provider's reports had indicated that improvements were being made to address the issues identified at the previous inspection. We found that although action had been taken and some of the regulations were being met, improvements needed to continue to meet further breaches of regulations found at this inspection, which means the service will remain in special measures.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service did not demonstrated to us that improvements have been made and therefore is rated as inadequate overall. This service remains in Special Measures.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures. During this inspection, we identified a number of continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had not had a registered manager in post since October 2017. 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.

Risks remained to some people as they were not consistently assessed or managed to keep them safe. People particularly at risk were those people living with dementia, and those people with complex health needs and behaviours. People required staff to supervise them to keep them safe. We observed occasions when people were unsupervised. Records identified people were at risk of harm if left unsupervised.

We observed a number of good examples of risks to people being identified, reported, however we also identified instances where risks had not been adequately assessed or mitigated. People and staff were placed at risk of injury when moving and assisting. This was because the wrong equipment was used and staff had not received the correct training.

People and relatives spoke highly about some staff. Some staff were seen to be kind and caring. However not all interactions were seen to ensure people were treated with dignity and respect. Care was seen to be task led, and some care not person centred.

The deployment of staff was ineffective and was not always consistently safe to meet people's needs and protect them from harm. The home had enough staff to meet people's identified needs although there were occasions during the inspection when staff appeared to be more task focused with this limiting the length of time they could spend talking with people.

The management of medicines was not consistently safe. People may be put at risk through not having their prescribed medicines and medicines administered were not always recorded. We observed there were 12 records missing for people in regards their management of medicines. This meant people may be put at risk through not having their prescribed medicines, and medicines administered were not always recorded.

Staff who administered medicines had received training. We were informed that they had undergone competency assessments in the handling of medicines but only one staff assessment was available for review.

Diabetic care plans were in place and staff were aware of the risk to people in regards their diabetic care. However records gave conflicting information. Although nurses were able to discuss which instruction they needed to follow, they seemed confused to which paperwork was correct. There was a risk that any staff who were not familiar with the care plans or risk to the person may not have been able to follow the care plan.

Some people's care records continued to contain errors and duplicated information preventing them from being person centred. This included the wrong names and wrong information. The records were not easy to find to allow easy access and review. System and process were not in place to ensure accidents and incidents were monitored or measures put in place to reduce the likelihood of reoccurrence.

People were not always treated in a respectful way, and care provided was task led. Staff did not always communicate with people when supporting them with food, drink or moving. People were not always able to receive personal care when required or as their care plan stated.

There were different standards for people living on the ground floor to people living on the first floor. People on the ground floor had rooms that were personalised. People on the first floor did not have their rooms personalised. This did not demonstrate a clear understanding of equality and diversity.

People's rights under the principles of the Mental Capacity Act 2005 were not always upheld. We identified some concerns relating to the five principles of the Mental Capacity Act 2005 (MCA). People had moved rooms, although this had been discussed with the relevant health professionals and family, records were not kept that demonstrated how and who made the decision in the person best interest.

People's nutritional needs were taken into consideration. Some people were at risk of weight loss, measures were in place to monitor people weight on a regular basis. However people were observed being served lukewarm food. The heated trolley was only able to be heated in the kitchen. Therefore once it left the kitchen food had no way of staying hot.

The systems in place to assess and monitor the quality and safety of the service had not been effective in identifying some of the concerns we found during this inspection. Although concerns had been raised during the previous inspection, inadequate efforts had been made to improve in those areas.

People did not have access to sufficient opportunities to leave the service, to socialise or take part in activities that met their individual needs and interests. Creative measures had not been taken to ensure people had access to activities which met their preferences or their needs.

There was a complaints process in place which relatives told us they understood. The complaints procedure was displayed in the entrance to the home. People and their relatives told us they would be confident to raise and complaint.

Where required the service was capable of providing end of life care to people and received support from specialist to do this.

The premises and the equipment were well maintained. Regular checks were undertaken in relation to the environment, maintenance and the safety of equipment. Good infection control practices were in use and there were specific infection control measures used in the kitchens and the laundry rooms.

We found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to the more serious 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 and staff were placed at risk of injury when moving and assisting people because the wrong equipment was used and staff did not have the appropriate training.

Medicines were not managed appropriately and people were not adequately protected from abuse or harm.

People were not always protected from the risk of harm as guidance to their assessed support was not always followed.

Staff were not appropriately deployed to meet peoples' individual needs.

Staff understood the signs of abuse and how to raise concerns. When concerns were raised these were not always responded to.

Is the service effective?

Requires Improvement

The service was not effective.

People's rights were not always respected under the Mental Capacity Act 2005.

Not all staff felt supported and regular supervisions were not taking place.

People were supported by staff who had not always had training to ensure they had the correct competency and skills to support them.

People had enough to eat and drink to meet their health needs. However, food was not always served hot.

People had access to external healthcare professional when they needed them

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with dignity and respect.

People personal possessions were not protected.

People were supported by staff who knew them well.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care as outlined in their care plans.

People did not always have access to activities which met their preferences or their needs.

People were not always provided with information or formats that helped them to communicate their needs.

Improvements were required in relation to providing people with accessible information.

Relatives told us they felt comfortable making complaints and records showed where these had been made they had been dealt with.

Is the service well-led?

Inadequate

The service was not well led.

There had not been a registered manager in post since October 2017 and the management had been inconsistent.

The systems in place to monitor the quality and safety of the service and drive forward improvements were not effective.

The provider sought input from external agencies and organisations to try and make improvements in service delivery.

Chestnut House Nursing 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.

The inspection was prompted by concerns shared with us about the lack of improvement in the standards of care at Chestnut House Nursing Home by the local authority and commissioning groups.

The inspection was completed by two adult social care inspectors, a specialist advisor, who specialism was nursing care and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the first day we were supported by pharmacist inspector, and on the third day an assistant inspector.

Before the inspection we reviewed previous inspection reports. We also reviewed other information we had received about the home, including notifications. Notifications are information about specific important events the service is legally required to send to us.

We did not request a Provider Information Return (PIR) prior to our inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We gathered this information during the inspection. We obtained the views of the service from the local safeguarding team and Clinical Commissioning Group prior to our inspection and during our inspection.

Most people who lived in Chestnut House Nursing Home were unable to talk to us about their experience of the service. Where people were able to share their experiences with us we spent time speaking with them but where they were not we used the principles of SOFI to aid our observations. SOFI (Short Observational

Framework for Inspection) is a specific way of observing care to help us understand the experience of people who are unable to talk to us.

During the inspection we spoke with 19 members of care staff, 10 people living at the home, seven relatives, two visiting healthcare professionals, the interim manager, regional manager, group clinical lead, clinical lead, three nurses, housekeeping staff, kitchen staff and the nominated individual. We also received feedback from two external healthcare professionals. We looked at five staff files, 22 medicine records, 15 people's care records and quality monitoring audits.

Inadequate

Is the service safe?

Our findings

At the inspection in October 2017 we found people's risks were not consistently managed. Medicines were not managed appropriately and people were not adequately protected from abuse or harm. Staff were not appropriately deployed to meet peoples' individual needs. We imposed a condition on the provider's registration requiring them to report to us monthly detailing their monitoring of the service and the action they were taking in response to their monitoring to improve the service.

The provider reports had indicated that improvements were being made in reporting safeguarding concerns, wound management, the management of medicines, and competency checks for all staff. At this inspection we found not enough action had been taken to ensure people received safe care and treatment. There remained a repeated breach of regulation 12 of the Health and Social Care Act.

People at risk of falling were not supported adequately to keep them safe. Staff were able to identify the people who were at high risks of falls, but did not protect them. For example, some people who were at risk of falls were seen to be walking without suitable footwear which could cause them to trip. Staff told us they did try to support people to wear appropriate footwear. One member of staff said, "We could put their slippers on 100 times a day and they just take them off so there is no point". We pointed out to another member of staff the sole on one person slipper was coming away, they told us, "We have to wait until the family buy them new ones."

People were not supported to transfer safely. On three occasions we observed people at risk from poor moving and assisting practice. One person was being transferred from their wheelchair to a chair with a toileting sling instead of a full body sling. The persons falls and safety care plan identified the correct sling the person needed. Staff confirmed they were not using the correct slings to transfer the person. They agreed it was an unsafe way to move the person. A member of staff informed us, that they had requested a full body sling many times. Another person was observed to try to stand up in their wheelchair and slipped because the safety strap had not been used. The person did not come to any harm as staff were available to support.

Care plans contained risk assessments which identified the correct position people should be in before they were supported to transfer. We observed one person being lifted from their wheelchair to a chair. The person's feet were not on the foot rests, which meant they were at risk of receiving a skin tear. We asked a senior member of staff to stop the move and ensure the person was in the correct position before commencing with the transfer. Records demonstrated on the 3 May 2018, the person had been injured whilst being supported to move. The preventative outcome was recorded to "Ensure [person's name] was stable when being supported with transfers. The senior member of staff agreed the person had not been supported appropriately to keep them safe. On a second day of inspection we observed the same person being moved in the same unsafe manner as observed the previous day.

The management of medicines was not consistently safe. When people had medicines prescribed to be taken "when required", care plans contained information about the condition the medicines were

prescribed for and sufficient detail of actions and assessments that need to take place before administration. When these medicines were administered a record was made of how the decision to administer had been taken. We checked associated care plans and found that 12 were missing in regards PRN medicines. This meant that people could not be assured that they were receiving these medicines in a safe and effective way

People were not always protected from the risk of harm relating to their conditions. Diabetic care plans were in place and staff were aware of the risk to people in regards their diabetic care. However records gave conflicting information. Some information on the care plans was not always legible For example one person's diabetic plan had the amount of insulin dose scribbled out and another instruction written over it. There were not clear witnessed signatures or dates to identify who had changed the instructions, and when discussed staff seemed unsure which guidelines they were following. A visiting community health professional told us they remained concerned that staff were not following their instruction in regards diabetic care. They told us, "On at least two occasions I have supplied the home with new hypoglycaemia management charts. However, on both occasions the hypo has been treated without following the correct treatment." Hypoglycaemia is when blood sugar levels fall. One person was found to have experienced hypoglycaemic event in the evening of day one of inspection and guidelines had not been followed.

People required staff to supervise them to keep them safe. We observed occasions when people were unsupervised. Staff on the first floor told us they tried to keep a member of staff free to observe people. On each day of the inspection we observed people walking into other people's bedrooms on numerous occasions. Staff did not intervene to stop them going into different rooms. Handover sheet gave example of people being hurt when staff had not been present, for example the handover sheet on 24 and 25 May 2018 stated that one person had caused damage to a communal area. On the same handover sheet staff had written in regards another person, 'found with top of radiator cover across neck. The completed incident form and staff confirmed no staff member had been present when the incident happened. The risk to people being hurt with parts of radiators had been identified by the provider and new radiators were being fitted at the time of the inspection. One member of staff told us "When there are three people on duty it is difficult to manage the risk to people we have to watch them all the time".

On the second day of the inspection we observed people being supported into the garden to sit in the sun. It was a hot day. Although one person told us they liked to sit in the sun and did not wish to wear a hat or any sun block, others would not have been unable to communicate if they wished to go back inside they were reliant on staff observations to take them back inside. People were not sat in the shade or under parasols; they did not have sun hats on although staff told us they had applied sun block.

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

The provider was engaged in an improvement forum following a number of issues identified at the last inspection

Staff understood the signs of abuse and how to raise concerns. Although staff and relatives knew how to raise concerns and had confidence that they would be listened to, there was not always robust tracking and follow up on occasions staffed raised concerns. Concerns had been raised regarding a care workers practice, but there were no details recorded as to how these concerns were responded to and the management team were not aware of the actions taken. Without this tracking and follow up people are at increased risk of abuse and staff do not receive the support they may require.

Staff were unable to tell us if any action was taken once incident forms had been completed. One member of staff told us, "If there is an incident we tell the nurses and they fill in the forms". Staff did not have confidence that action would be taken by manager for any concerns raised. Comments included, "Not sure what happens to forms they get moved into different files". "Don't think they are looked at as we're not often asked about them". "We don't always fill the forms in to be honest."

There was a rolling programme of in-house staff fire training. Some staff told us that they were not aware of what to do in the event of a fire. People had Personal Emergency Evacuation Plans (PEEPS) on their files. These guide staff on the most appropriate way to support people to get out of the home safely in the event of an emergency such as a fire or flooding. One member of staff told us that fire marshals had been chosen but had not yet received training for this role. The resident list that accompanied the fire log held incorrect information in regards which rooms were empty and which room's people were occupied and by whom. Staff were living at the home who were not on the fire list. We advised the senior management team to update the list. Following the inspection the fire service identified issues with fire safety and asked the provider to make improvements in relation to gaps in fire doors increasing the risk of smoke spreading.

Staff were clear on their responsibilities in regards infection control. There were ample hand washing facilities throughout the building and staff had access to personal protective equipment such as disposable aprons and gloves. Staff were able to discuss their responsibilities in relation to infection control and hygiene. Signage around the home reminded people, staff and visitors to the home of the importance of maintaining good hygiene practices.

Arrangements were in place for the safe storage of medicines including those that require temperature controlled storage and those that require additional security. The service had arrangements in place to use homely remedies. These are medicines that can be bought over the counter for the treatment of minor illnesses. These medicines were available to be used and there were clear records when they had been used.

Some people in the service were prescribed thickening agents to help prevent choking when taking fluids. Only one type of thickener was prescribed. Staff were aware of how to make up the thickener to required consistency.

The home had enough staff to meet people's identified needs although there were occasions during the inspection when staff appeared to be more task focused with this limiting the length of time they could spend talking with people. A staff member replied, "Not really" when we asked if there was enough time to engage with people meaningfully. Another told us they were "Coping as there were only a few residents, I don't know what will happen when more come in." The home used a dependency tool to help ensure there were sufficient staff to meet people's current and changing needs. This was last reviewed at the end of April 2018. One relative said, "I don't think staffing levels are too bad now."

We looked at call bell records. These showed that people were supported in a reasonable time when they indicated they needed support. This was confirmed through our observations. One person said "I don't see a lot of staff but when I ring my bell they come quickly." The home did not audit call bell records. This would show them trends in call and responses times and offer an opportunity to improve the service people experience.

The service had a suitable recruitment procedure. Recruitment checks were in place and demonstrated that people employed had satisfactory skills and knowledge needed to care for people. All staff files contained appropriate checks, such as references, employment histories and a Disclosure and Barring Service (DBS) check. The DBS checks people's criminal record history and their suitability to work with vulnerable people.

In addition appropriate recruitment checks had also been completed for all members of the provider's senior management team.

Relatives told us they felt their family members were safe. Comments included, 'I know [name] is safe when I leave her.' Another relative told us, "I know [name] is being looked after." "I understand there has been poor staffing levels over the past year. Plus there has been several managers coming and going. But I think it is beginning to improve'.

Requires Improvement

Is the service effective?

Our findings

At the inspection in October 2017 we found people did not receive effective care and support because staff did not act in accordance with the requirements of the Mental Capacity Act 2005 (MCA) when seeking consent to care, or in the monitoring of their hydration needs. Staff did not always have the appropriate training required to meet needs. We imposed a condition on the provider's registration requiring them to report to us monthly detailing their monitoring of the service and the action they were taking in response to their monitoring to improve the service.

The provider reports had indicated that improvements were being made in ensuring people received effective care and treatment in regards support from MCA champion who had received extra training in regards MCA. All staff received supervisions and additional training. At this inspection we found although some improvements had been made, additional improvements were still required, to ensure people received effective treatment in regards protection not to deprive them of their liberty and to be supported by staff who had the appropriate skills to enable them to carry out their duties. We found continued breaches in Regulations 11, 13 and 18 of the Health and Social Care Act.

People living at Chestnut House had a variety of needs, with some people living with forms of cognitive impairments which could affect their ability to make decisions. We checked whether the provider was working within the principles of The Mental Capacity Act 2005 (MCA). 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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Where people lacked capacity to make decisions or give consent, staff did not act in accordance with the MCA. Mental capacity assessments and best interest decisions had not been fully completed in line with the principles of the MCA. For example, although mental capacity assessments were completed to support decisions around things such as personal care, support with medicines and the taking of photos; where best interest decision meetings then took place these did not always involve input from the person, relatives, health professionals or any person or body with the legal authority to act on the person's behalf.

We looked at two people's records one of who had a Lasting Power of Attorney (LPA) for health and welfare decisions, and the other a deputy. These people had not been involved in best interest's decision meetings. One record showed the LPA had been informed of the decision after the best interests meeting. The other record showed no communication with the deputy. We raised this with the interim manager who told us communication would go out to all the nurses to involve LPAs and deputies in future and that this would be reviewed at the next clinical review meeting. On occasions where people had been supported to move rooms the management confirmed that the people's consent had not been sought and no best interest decision meetings had been held.

Care files held Mental Capacity Act and Best Interest documentation for people who lacked the mental

capacity to make decisions about their medicines. Records showed for two people although they were being given their medicines covertly no best interest decision had been made. Therefore people were given medicines covertly without an assessment of their capacity or consideration of their best interests.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Five people had been granted DoLS with conditions attached. These conditions were detailed in their care plans and known to some of the staff. Although the home had an up to date record of who was subject to DoLS, conditions attached to the DoLS, and renewal dates, there was no monitoring whether the conditions were being met. Activity records and our observations showed staff were not consistently meeting the conditions. For example where conditions stated people had to be taken out on a daily basis this was not happening. One person's records from 14 May – 21 May showed no written evidence they had been supported outside of the home. Another person's records only showed they were supported outside when they became anxious. We brought to the management's attention that one person's DoLS had expired 10 days prior to the inspection. Until we raised this they were not aware. The home put a DoLS matrix in place at the beginning of May 2018. They immediately reapplied for this person's DoLS. We also observed that the list of people with DoLS conditions in the nurses' station was out of date. It listed three people as having conditions on the first floor when the correct number was four. We made the senior managers aware of this.

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

People did not receive support from staff who had the knowledge and skills they needed to carry out all aspects of their roles. Some relatives raised concerns with us about how staff were trained and supported to provide appropriate care. One relative told us, "I do question if some of the staff have had the correct training". We observed poor practice in regards moving and assisting. One member of staff told us they had not received any moving and assisting training or competency checks since beginning work at Chestnut House. They told us, "I have done training were I worked before but not here. They told us although they were able to support people to transfer their competency had not been checked.

Another member of staff told us they had returned to work after a significant period away. They told us, "There are so many changes with management, residents and staff. I haven't received any formal support or refresher training. In the time I have been away people's needs have changed. "We don't get time to read care plans. I just ask." This meant people were at risk of being supported by staff who did not have the correct skills and knowledge to carry out their roles.

People were supported by staff who had not always had a formal induction when starting at the home. This meant that new staff were not supported to help them to adjust to their new roles and working environments. We reviewed five staff files. Two new staff had not had an induction or supervision although had worked at the home for a number of weeks and months respectively.

Staff told us they had not being receiving any form of supervisions. A member of staff told us, "I have not had any supervisions or checks that checked I am ok". Records provided showed staff were not receiving supervision and appraisals as expected by the provider and in line with their policy. Supervisions are mechanisms which support staff. We raised our concerns with the regional manager who told us they were

intending to introduce a supervision matrix which detailed lines of responsibility with regards to delivering supervisions. At the time of the inspection no dates had been added to this matrix.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had received specific training since the last inspection which related to some of the concerns raised. This included areas such as mental capacity, equality, diversity and human rights (EDHR), supporting people whose behaviour challenges, dementia and diabetes. One member of staff told us, "A trainer came in to talk to us about supporting different behaviours, it has helped." Another member of staff told us. "It is better now we have new knowledge on supporting people with dementia, and can ask for support when residents are being challenging. The provider told us additional training had been put in place following the last inspection which included face to face learning."

On moving to the home people had a nutritional care needs assessment. A copy of this was then given to kitchen staff and a held on the person's care plan. Every three months the chef held a meeting with people and their relatives to create the menu. Regular checks were made to ensure people were given sufficient to drink and eat. Weight charts were in place and showed people weights were being monitored. Weekly clinical meetings were held where people at risk of malnutrition were discussed. Staff told us if people were not drinking or eating enough this was discussed at handover. Fluid charts showed the amount people were drinking against their suggested targets. People had access to drinks outside of the arranged refreshment rounds. Juice machines were available for people to have drinks. A coffee and tea machine was available in the lobby of the home.

On two days of the inspection people were observed being served lukewarm food, the chef told us the heated trolley was only able to be heated in the kitchen. Therefore once the trolley left the kitchen food had no way of staying hot. They informed us, there were no further checks that the food was being served hot. We were informed there had been an issue with heating the trolleys for a period of approximately six months. The regional manager had not been aware of the issue and took action to ensure new heated trolleys were ordered.

At lunchtime most staff supported people at a relaxed pace to eat giving them time to finish their mouthful before they were offered the next mouthful. They were offered time and given information on their food and drink. However, some interactions were not so positive. We observed some staff who did not assist people in an effective manner. One member of staff was observed to stand over a person to assist them with their snack. They did not engage with them and took their drink away without ensuring they had enough to drink. The person would have been unable to ask the staff member to bring their drink back. Another member of staff was supporting a person with their lunch, they did not inform the person what they were eating or give them space to take their time or have a drink in between mouthfuls of food.

People were supported by staff to see healthcare professionals such as GPs, specialist nurses, neurologists, psychologists, district nurses, occupational health practitioners, opticians and dentists. We found examples of staff identifying concerns or changes in people's needs, raising this with outside professionals, however some health professional remained concerned their instruction were not always followed. The provider was linking closely with professionals and told us instructions were sometimes confusing or conflicting. We observed some records held conflicting instruction. Senior staff informed us if they were unsure of the guidance they contacted the professional involved.

Lounges and dining areas had been themed throughout the home to bring stimulation and help people to

know where they were however it was noticed there were differences on both floors. There was a distinct difference in the design and decoration of people's rooms and communal areas between the ground and first floor. People on the first floor had dementia. Their rooms lacked personalisation and were sparse and clinical. We spoke to a relative about this who said, "I would love to see [name's] room more homely but [name] would break everything." People's rooms on the first floor were in contrast to people's rooms on the ground floor who were more able. Their rooms were personalised and there was a homely feel to the area where they lived. We discussed our concerns with the senior management team in regards the different of standards between the ground floor and first floor. They informed us, "We are noticing what changes need to take place, and it takes times to identify what need to change". It was recognised by the management that there was work to do in the garden in terms of making areas of it dementia friendly, for example, creating a circular walk so that people could explore with purpose

On the third day of the inspection there was a noticeable change on the first floor with newly painted walls, pictures on walls and rummage boxes for people to take items such as hats from. Staff told us it was good that improvements had begun.

Requires Improvement

Is the service caring?

Our findings

At the inspection in October 2017 we found people were not always treated with dignity and respect as people's personal care needs were not always met and not all people were treated in a respectful way. We imposed a condition on the provider's registration requiring them to report to us monthly detailing their monitoring of the service and the action they were taking in response to their monitoring to improve the service.

The provider reports had indicated that improvements were being made in regards person centred care. At this inspection we found improvements were still required and not enough action had been taken to ensure people were treated with dignity and respect in regards their personal care needs being met. We found a continued breach of regulation 10 of the Health and Social Care Act.

The provider reports had indicated that all staff were to attend person centred care training in June 2018. At this inspection concerns were still raised in regards people not being treated with dignity and respect.

Not all people were treated in a respectful way and care provided was task led. Staff did not always communicate with people when supporting them with food, drink or moving. One relative told us they had noted that some staff were, "Not particularly nice" in regards to dignity and respect. They said, "I see some staff helping people but not talking to them. It does not take much to hold someone's hand and reassure them. There are still some of the old staff team who don't embrace change. They still refer to people as the walkers'. This was confirmed when a member of staff referred to people living at the service on the first floor as 'the walkers' to a member of the inspection team. Another member of staff told us they had been advised not to name slings, "Because people pass away".

People's privacy was not always respected. We observed when people were choosing to stay in their rooms their doors were wide open, which did not respect their privacy. A staff member said this was mostly for the benefit of staff who were then able to monitor people more easily. People's care records held no information that indicated that they had been asked whether they wanted their door open or closed during the day time.

People were not always supported with personal care as they wished or required. We observed one person who needed immediate support with personal care. Although there were two staff members in the communal area with the person, we were informed they would have to wait until staff came into the room or other staff came off their break as they both could not leave the room, and the person needed support by two members of staff because of their behaviour. The person was left in an undignified manner until another member of staff returned from their break.

People's care plans identified their likes and dislikes, this included if they liked to have a shower. One person's records stated the person liked to have a shower at least two times a week. Records for the person which showed they had not been offered a shower or hair wash for two weeks.

Some people were referred to as, 'difficult to support with personal care'. Charts held in the nurse's station showed us the days that people needed to be offered support with a shower. The chart held the names of six people who were allocated set days to be supported with a shower. We checked daily records from the 21 May – 31 May 2018 for the six people. There were no recorded entries of anyone being supported with a shower. Staff confirmed it was difficult to support people with personal care, one member of staff told us, "We don't always have time to support people with showers, there used to be tick list in the folder but that is not there now so there is no way of knowing when someone last had a shower."

People personal possessions were not protected. One member of staff told us, "It is difficult as they go into each other's rooms and take things." One relative told us people's rooms were not personalised because some people living with dementia went into other people's rooms and removed belongings. They discussed personal experiences of their loved ones belongings being taken from their room.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

During our inspection we observed some positive, kind and caring interactions between staff and people living at Chestnut House Nursing Home. People were supported by staff who knew them well. Staff made a number of comments to us which demonstrated how much they cared for people and enjoyed their personalities and individual attributes. For instance, telling the inspection team about people's past. Relatives told us they were very happy with the support their loved one received. Comments included. "I can't fault the care the staff are always caring and approachable and look after my [loved one] very well. "The attitudes of staff are very caring, friendly and kind…it seems it's never too much trouble to help my [loved one] when they need it'. They are gentle with my [relative] and very patient when [name] gets agitated. The staff take him for walks when the weather allows', 'The staff are always caring and approachable and look after [relative] well' and 'All the staff are very welcoming to me and my family.'

People were supported to make decisions even if this could be seen as something untypical for example if people expressed a wish to have their curtains closed in their room during the day this was documented and supported. People told us and records confirmed that they were supported in a way that helped them retain the skills they still had.

Requires Improvement

Is the service responsive?

Our findings

At the inspection in October 2017 we found people were did not always received person centred care outlined in their care plans. We imposed a condition on the provider's registration requiring them to report to us monthly detailing their monitoring of the service and the action they were taking in response to their monitoring to improve the service.

The provider reports had indicated that improvements were being made in events and activities committee to be set up, staff members to become more activity focused, Care plans to be reviewed monthly as part of residents of the day. At this inspection we found although some improvements had been made, additional improvements were still required in regards people receiving personalised care and treatment. We found a continued breach in Regulation 9 of the Health and Social Care Act.

We found improvements were required in relation to accessible information. Each person's care plan detailed people's communication methods and how best to speak with and understand people, however we found there was a lack of information for people in a format they could understand. This was not in line with the accessible information standard. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need.

People did not have care plans in formats they could understand, such as pictures or videos, and therefore did not have access to information about their own health and care in a personalised way. One person who first language was not English and was not able to communicate their needs clearly to staff. Staff told us they "managed just" with hand motions and gestures. We raised this with the management. The following day we saw that communication cards with common phrases had been made and that these were being used by staff to interact with this person. Contact had also been made with the person's relative to request that a phrase book be brought in to allow staff to interact in a more personalised way with this person.

Each person had their needs assessed before they moved into the home. This was to make sure the home was appropriate to meet the person's needs and expectations. Care plans included information that guided staff in how to support people's assessed needs. This included where they had particular health conditions such as diabetes and osteoporosis. The care plans were being updated at the time of the inspection. The plans included details of people's life histories, preferences and social interests with involvement from relatives. Not all staff had read the care plans, and told us they relied on each other to share information. The regional manager told us they had been focusing on improving care plans to ensure they met with the provider's standards. They informed us they were not on target to complete full reviews of their care plans, but wanted to ensure the care plans were reflective of people current needs and risks

There was not enough space for people to sit in one lounge without being seated in front of other people. On one occasion there were 12 people in the lounge area with four large tilt back chairs. This meant that some people were sat in the middle of the lounge, on some occasions in front of others. Relatives told us they felt concerned about the amount of people in the lounge.

Measures had not been taken to ensure people had access to activities which met their preferences or their needs. People were sleepy and seemed to lack motivation, or walked up and down the corridors or sat by the main entrance as if waiting for someone. Daily records did not reflect what people had been doing during the day or how they were presenting in mood. Record did not reflect what people had been doing or how they were feeling. Most daily records indicated that the person' remained settled or agitated' , there was no further explanation of events in the person's day.

There was little stimulation for people. Staff were task focused, and seen to be preoccupied with tasks. On the first floor people had little or no activities to stimulate them. On the first day of the inspection people were seen to wonder in corridors or sleep in chairs.

There were not enough opportunities for people to go out of the service, to socialise or to take part in activities that met their social needs. Relatives and staff felt this was the case and we saw from records people did not have many opportunities to go out unless with family or friends. The home had a mini bus, but staff told us this was not used as there were not many staff who could drive it.

Activity co-coordinators were employed to support people to remain active, however the regional manager told us there were vacancies, which meant other staff back filled the role. There was an activity programme and photographs on wall on the ground floor that showed us what activities had taken place. On the third day of the inspection activities had improved on both floors. People were seen to enjoy the musical entertainers, by either dancing, singing along or just tapping their feet.

The provider had recognised that improvements were required with the activities on offer to people. This had resulted in the recent setting up of an activities forum. This was done to give people and their relatives influence over what activities were on the weekly programme. Prior to this the activity lead decided what was on the activities calendar. We were told that no people attended the first activities forum as there was a lack of notice that it was taking place. If this is to be a people and relative led activities programme then every attempt needs to be made to capture their views. The activity lead told us they had the support of the interim manager in improving the activities on offer and were in discussions with them to make it more imaginative and inclusive.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The service had an end of life care policy, guidance and procedure in place. At the time of our inspection staff told us there were no people with end of life care support needs. Care plans included advance care planning noting when people had expressed a wish not to be resuscitated. The care plans also identified people's spiritual and religious needs. Some of the staff told us they had previously supported people with end of life care needs. These staff were able to describe how they would respond and who they would involve if people at the service needed this support. One relative said, "My father was also in the home and was well looked after and died with dignity." At the time of the inspection nobody was receiving end of life care.

The home had a complaints policy and procedure that was on display in the entrance to the home. There had been one complaint recorded since the last inspection. On receipt of the complaint an investigation had started and the home had met with the person's family and their social worker within five days to review actions taken to resolve the issue.

The provider collected positive feedback from relatives and visitors to the home. For example in April 2018

the results of their satisfaction survey scored the home 4.2/5 out of 5 this included 4.1 for care delivery and 4.4 for staff attitude. Relatives told us they had completed surveys and were happy that the provider kept them informed of events in the home.

Inadequate

Is the service well-led?

Our findings

At the inspection in October 2017 we found systems in place to monitor the quality and safety of the service and drive forward improvements were not effective. Audits and quality assurance systems did not always identify shortfalls in the requirements of the regulations being met. We imposed a condition on the provider's registration requiring them to report to us monthly detailing their monitoring of the service and the action they were taking in response to their monitoring to improve the service.

The provider reports had indicated that improvements were being made in the monitoring and auditing of the service. Records, policy and procedures were being updated, and changes in management were taking place to reflect the improvements within the service. At this inspection we found the provider had not identified shortfalls in maintaining accurate, complete and contemporaneous records, people's daily monitoring charts were incomplete and included gaps. There remained a lack of oversight into the quality assurances and governance of the service. We found a continuing breach of Regulation 17.

The service had not had a registered manager in place since October 2017. 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. There have been three management changes since the last inspection in October 2017. An interim manager took up position on 22 May 2018 for a six month period. The interim manager informed us they would be applying the Care Quality Commission to become the registered manager.

The governance systems in place were not effective in identifying all of the shortfalls we found during our inspection. Audits and checks did not identify where the service was not meeting the requirements of the regulations, such as adhering to DoLS conditions and the poor standards of care identified by CQC and other healthcare professionals.

Activity staff did not have a record of people that had conditions attached to their DoLS authorisations and not all knew what the conditions were. This meant there was a reliance on the activity lead knowing this information and reminding the activity coordinators. The home had recently lost two activity coordinators which had put pressure on the number and range of activities offered. One of staff member said, "I think people have missed out today as there is only me on."

At the last inspection people's records were not consistently completed. At this inspection we found records continued to be inconsistently completed. People's records continued not to be consistently completed so there was an accurate, contemporaneous record. Some contain errors and duplicated information preventing them from being person centred. This included the wrong names and wrong information. The records were not easy to find to allow easy access and review. Staff informed us records such as incident, accident and daily records were removed from files on a monthly basis and 'stored in cabinets in the nurse's station'. The provider told us that accident and incident reports were reviewed and a copy was held in the home manager's office after being signed off for monthly review.

There was a lack of oversight to ensure records were accurate, up to date and completed in a timely manner. People's records were not always accurate and therefore people were at risk of not receiving the care they required. For example, one incident form completed on12 May 2018 informed us a person at high risk of falls had fallen at 14.45 and had been taken to hospital. The daily records stated the person had fallen at 15.30, but there were no apparent injuries although the emergency services had been called as a precaution the person remained at the home. We spoke with the senior on duty, who informed us the information was in regards two different people, and they had "missed this" when checking the records.

There remained concerns that no systems in place to review the high number of incidents of staff being hit by service users. We found although there were monthly records of incidents and accidents, system and process had not been improved to ensure accidents and incidents were monitored or measures put in place to reduce the likelihood of reoccurrence.

Although senior staff completed a monthly trend analysis of the amount of accidents and incidents, this information was not always shared. For example when people displayed behaviours that challenged staff completed ABC charts in line with people care plans." Records showed us in a period from 13 April 2018 to 21 May 2018 one person had shown behaviour that challenged staff on 12 separate occasions. Although the matrix evidenced the number of monthly incidents had been recorded staff could not demonstrate how these had been investigated to make sure action was taken to mitigate the risk or identify lessons learnt

Some systems did not support people's safety. For example people were not always living in the rooms that they were detailed under on the room list. We saw numerous errors in the records held on occupancy of bedrooms. The management said that this was due to people recently moving rooms. When we checked some of these people had moved rooms between one and four times prior to the inspection. The room list was updated after we raised this.

At the last inspection systems and processes were not in place that identified shortfalls. We found systems and processes had not identified that although the Medicine Administration Records [MAR] were checked twice a day for any gaps. Any gaps on the MAR charts were investigated and recorded as incidents if the issue could not be resolved. If the issue was resolved, e.g. medicine had been administered but had not been signed for, this was not recorded in the incidents log and therefore there was no overview of the frequency of this type of error or record if the same member of staff was making repeated errors.

Staff who administered medicines had received training. We were informed that they had undergone competency assessments in the handling of medicines but only one staff assessment was available for review. On the third day of the inspection we were told competency assessments were taking place for all staff who administered medicines. This meant there was inadequate or non-existent auditing in certain areas.

Auditing should have shown that certain staff had not received an induction, supervisions and there are gaps in training. There was a lack of communication between heads of departments to ensure the overall oversight to senior managers. For example, although heads of department meetings were held daily, information was not shared consistently or effectively with senior managers. Senior managers informed us they were aware this was an issue they needed to address.

Where changes had been made in response to our previous inspection, we found these had not been reviewed to identify whether they were having the required impact. The provider's improvement plan for the home recorded actions to be met by 30 May 2018. Some targets remained outstanding, such as training for all staff in activities, competency checks for all staff, mapping of meal times, care plan audits. The regional

manager informed us some targets had not been met due to changes in priorities given from CCG and the local authority.

The management structure has experienced a significant amount of instability in the last few months. The deputy manager had stepped down from their position. Staff told us the changes in management had been 'unsettling'. One member of staff told us. "There have been many management changes since the last inspection and lots of staff have left. We are not really sure what is happening".

The service continued to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

There were positive changes to the structure of the home since the new regional manager clinical group manager had taken positions. The provider told us there was oversight in regards to monitoring the service. They told us, key targets were gathered monthly and sent to the compliance team. Trends were reviewed and recommendations made. The new interim manager informed us that they had received a detailed overview of the service by the provider and was currently making their own assessment of the home.

The management team were focused and positive about moving the service forward. Staff told us they were hopeful the service would move forward. Relatives told us they remained happy that they were being kept up to date and informed of changes and improvement in the home. The provider had taken steps to promote good practice, highlight success and develop role models. For example, one member of staff was nominated as the employee of the month. Relative told us they felt more confident about the management of the service and were being kept informed of any concerns.

The provider sought input from external agencies and organisations to try and make improvements in service delivery. The management told us that their strategy was to work towards continuity and consistency and that would be achieved by a number of methods including holding clinical review meetings, heads of care meetings and putting in place critical auditing. Some of these were introduced during our inspection, including meal time and activity audits. The managers felt that their biggest challenge was improving and maintaining team morale given the inconsistency of the management structure.

The regional manager told us, they had been identifying the short falls in the short time they had been there. They were hopeful with the support of the new interim manager changes could be made quickly and proactively. They told us, "We need to ensure the lead of each department takes accountability and responsibility back. Currently there is a lack of consistency in the information being shared with us." They told us it was "Fundamentally the quality of care improved for residents and we take this home from inadequate to outstanding." They informed us their vision was to empower staff to feedback, improve morale and for head of departments to take responsibility.

The provider told us Chestnut House Nursing Home had regional management cover by a group on call rota to support all staff out of hours. They informed us management personnel had remained in close contact throughout the period following the last inspection. A compliance check was completed by the provider on 17 May 2018. Their report stated that improvement had been made, and 'the walk around revealed a much more positive and pleasant environment within the home.' They stated that improvements were required on the first floor in terms of engagement for people living with dementia, and suggested a budget to purchase new equipment to 'enhance' resident's daily life. They also identified the home's mini bus was rarely used which prevented people from being taken out of the home. They have recommended support for staff who are prepared to drive the mini bus. Activities were also discussed by senior managers as an area of improvement within their action plan.

The service was meeting its registration requirement to submit action plans to CQC on a monthly basis to update us on how they were implementing improvements and progress being made. Improvements had been made in relation to submitting statutory notifications. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them.

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 There were shortfalls as people did not always received person centred care as outlined in their care plans

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect There were shortfalls in regards treating people with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent There were shortfalls in seeking people's consent. People's rights were not protected because staff had not consistently acted in accordance with the Mental Capacity Act 2005 (MCA).

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

There were shortfalls in supporting people in accordance with the Mental Capacity Act 2005 Deprivation of Liberty Safeguards:

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

There were shortfalls record keeping and the governance systems at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing

There were shortfalls in ensuring staff received the appropriate training, professional development, supervision and appraisal.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were shortfalls in fully and consistently assessing and mitigating the risks to people receiving care.

The enforcement action we took:

We served a warning notice on 15 June 2018 requiring the provider to make sure people are safe by 25 July2018.