Care Quality Commission

Porthaven Care Homes Limited

Chiltern Grange Care Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Inadequate
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This unannounced inspection took place on the 26 and 27 October 2015. The home is registered to provide nursing or personal care for up to 75 young and older people including people who live with dementia. At the time of the inspection there were 58 people living in the home. 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. Previously the home had been inspected in July 2015, this was a focussed inspection to see if the home had made improvements in the areas of Safe, Effective and Responsive. It was rated as good in these areas.

At the time of the inspection there was a new manager who had commenced employment with the provider four weeks prior to the inspection. They intended to become the registered manager.

Summary of findings

During this inspection we found that infection control audits had been completed but there were no action plans in place to address the points of concern found in the audit. Legionella testing was not up to date and actions required to ensure the safety of the home in relation to legionella had not been completed.

The home was clean and well maintained. People had their own rooms and en-suite facilities. They were able to personalise their rooms with their own belongings.

People told us they felt safe living in the home, however, the manager was not aware of how to respond to allegations of abuse in such a way as to protect evidence. The home's whistleblowing policy did not ensure staff had clear information of how to report concerns outside of the home and where possible, their identity would be protected. The safeguarding policy made no reference to the multi-agency agreement and the local authorities expectations of how safeguarding concerns should be addressed in the home.

Some aspects of the administration of medicines was not safe for example, signing the medication administration record (MAR) prior to administering medicine to people. We also observed prescribed fluid thickeners were being shared between people, rather than each person receiving their own. This is not in line with the guidance from the Nursing and Midwifery Council (NMC).

Training and supervision had not always been carried out for all staff. We noted that according to the records, three staff members who were carrying out the administration of medicines had not received training to administer medicines to people and their competency had not been assessed. Regular supervision of staff did not always take place this meant the provider could not demonstrate they had monitored and supported staff in relation to the duties they were employed to perform

Checks were undertaken to ensure new employees were safe to work with people. Where agency staff were used, the agency provided the home with a profile showing that appropriate checks had been completed and their knowledge regarding policies and procedures was up to date.

People told us there were not enough staff; however on the day of the inspection we saw there were sufficient numbers of staff to provide the care and support necessary. A significant percentage of the staff in the home were agency staff, as there were approximately nine staff vacancies at the time of the inspection.

The requirements of the Mental Capacity Act 2005 were understood by some staff, and where required the home had made applications regarding the deprivation of liberty safeguards. We could see no documentation to show how staff acted in people's best interest when it came to making serious decisions that would affect people's lives.

Care records were not always completed accurately or updated appropriately. This meant monitoring of people's health and care needs was not effective.

We saw some positive interactions and strong relationships between some staff and people who lived in the home. However, we also saw poor communication between staff and people, and where two people who needed extra support with their food did not receive this from staff.

Records showed complaints were not always followed through in line with the home's procedure and the new regulations.

People participated in activities such as puzzles, board games, arts and crafts, sing-along and painting but plans were in place to improve the quality and the quantity of activities.

The frequent change in management over the last 14 months meant there had been no consistency in the management approach. There had also been a large turnover of care and nursing staff. The Care Quality Commission (CQC) had not always been informed about changes in the home that legally they are required to do.

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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe

The provider failed to ensure the prevention and spread of infection due to a lack of equipment and regular testing taking place.

The manager did not know how to respond appropriately and in line with the local authorities expectations with regards to safeguarding adults.

Medicines were not always requested or administered safely.

Requires improvement

Is the service effective?
The service was not effective.

Some staff were not adequately trained to carry out their role. Some staff did not receive regular supervision to enable them to carry out their duties and facilitate development of their abilities.

Mental capacity assessments were not always completed in line with the Mental Capacity Act 2005 (MCA). The provider was unable to provide documents to demonstrate where people lacked capacity to make decisions, they had acted in the person's best interest.

People's care needs related to nutrition and hydration was not always completed accurately. This placed people at risk of poor health.

Inadequate

Is the service caring?
The service was caring.

People spoke positively about the staff and we observed relationships had been formed between staff and people living in the home.

Staff were described as "loving and caring" and staff demonstrated how they protected people's dignity and privacy.

Care plans documented people's preferences and consent to care.

Good

Is the service responsive?
The service was not responsive.

We observed situations where the needs of people was not responded to by staff and therefore not met.

The procedure for dealing with complaints was not always in line with home's policy. Outcomes and investigation had not always been documented.

Requires improvement

Is the service well-led?
The service was not well led.

Requires improvement

Summary of findings

Although a new manager was in place at the time of the inspection, there had been no consistent management of the home over the previous 14 months.

The provider had failed to notify us of changes and events that had occurred in the home.

Some audits had been completed but monitoring and actions to manage the risks to people had not always been followed up.

Chiltern Grange Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 26 and 27 October 2015 and was unannounced. The inspection team comprised of three inspectors and an expert by experience who had experience of care for older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to and after the inspection, we reviewed previous inspection reports and other information we held about the home including notifications. Notifications are changes or events that occur at the service which the provider has a legal duty to inform us about.

During the inspection we spoke with 15 people who lived in the home, six visitors and 19 staff including the manager and regional manager. We carried out observations of care and reviewed documents related to approximately 20 peoples care and a range of medicines, care and monitoring records relating to the running of the home.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe living at Chiltern Grange. Comments included "The majority of staff are very nice and I feel safe here; they treat me with respect." People told us the staff were polite and that they felt safe from bullying.

As a way of preventing damage to people's skin from the pressure of lying or sitting in the same position for too long, the provider had put air mattresses and cushions in place for people at the highest risk. When we checked, we could see the inflated mattresses and cushions had different inflation settings. The associated care documents and the care staff told us this was aligned to people's individual body weights. However, nowhere in the documents did staff record what the specific setting for the person was meant to be. Therefore, when staff checked that the mattress or cushion was working they did not have the knowledge of or ability to ascertain if the setting was correct for the person at the time.

When staff checked the inflation of the mattresses or the cushions every two hours, they signed a recording sheet, with the exception of a couple of checks where no examination was documented. One person's mattress was disconnected from the air pump and flat at the time of our inspection, which meant pressure relief was not occurring for that period. Staff quickly re-connected the mattress to ensure that the person's risk of developing a pressure ulcer was again reduced. This placed people at risk of developing pressure ulcers if the staff were not aware of the correct setting of the mattress, and the checks did not identify when mattresses were deflated.

The home was observed to be clean and tidy throughout our inspection. Fittings and fixtures were in good condition, and were seen to be undamaged and kept unsoiled. Staff were unable to identify the infection control lead for the home. The infection control lead demonstrated excellent knowledge of infection prevention and had comprehensive and thorough practices and documentation in place which supported good practice. For example, we were shown how separate cleaning cloths, mops and buckets were used for certain cleaning, how these were disinfected and where supplies and equipment were stored and used. The cleaning staff also demonstrated safe handling, use and storage of chemicals and appropriate safety documents were in place in the event of a chemical spill or accident.

The home had a Whistleblowing policy. This directed staff on how to report any concerns they had about the care being provided in the home. However, the policy failed to highlight that anonymity of the whistle-blower would be protected as required by the Public Disclosure Act 1998. It also failed to make clear how and when a member of staff could approach an outside organisation in relation to their concerns.

The home had a safeguarding adult's policy and procedure. This guided staff on how to respond to concerns of abuse. However, it made no reference to the protection of evidence, or the local authority's procedure for the reporting and investigation of abuse. Furthermore, we found the registered manager was not aware of how to respond to safeguarding concerns in line with the local authority's multi-agency agreement. This placed people at a risk of harm if concerns were not reported correctly to the right authorities in a timely manner.

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

Staff members we spoke with told us they had completed safeguarding training, usually including a face to face training session. They were aware of types and indicators of possible abuse and their responsibility to report any concerns. A carer told us they would "report to the nurse and manager." They also mentioned possibly reporting to the company. Staff we spoke with were aware of the role of other agencies such as the local authority and the police in safeguarding adults and contact details were displayed at the nursing or care station areas of each unit. Training was available to staff to ensure they were aware of the indicators of abuse and how to respond if they had concerns. Records showed all the home staff had completed this training.

We observed the administration of medicines and spoke with staff responsible for medicines on each of the three units. We saw that the service had a medicines policy which covered topics such as what to do in the event of a medication error and who to inform should an error occur.

When we observed a medicine round on the ground floor, we noticed that the medicine technician/senior carer was signing medication administration records (MAR) for people before giving the medicines. The team leader told us the carer was "signing them out" and was signing before administering because "certain residents we know will take

Requires improvement

Is the service safe?

them." This practice was not safe and did not meet the requirements of the provider's policy and procedure for the safe administration of medicines or of national guidance from the Nursing and Midwifery Council (NMC). We cross referenced the information on the training matrix with the staff rota. We noted that three nurses and a carer responsible for the administration of medicines had not attended medication training, neither had their competency in administering medicines been assessed. This placed people at risk of harm because the provider could not be assured of the competency of the staff when administering medicines to people.

We also observed that the nurse on the second floor added a scoop of thickener powder to a drink for a person who had been prescribed this thickener. This was to ensure the drink was the right consistency to prevent the person choking. We noted one person's prescribed thickener was being used for five people. We pointed this out, the nurse told us "We usually put one" box of thickener out on the medicine trolley. We saw that five people required thickener and that these had been prescribed individually. The nurses acted to add the other individual boxes to the medicine trolley. Following the inspection we were made aware of concerns raised by local health professionals regarding the management of medicines in the home. These were being reviewed by the local authority safeguarding team.

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

We saw that the nurses on the first and second floor who carried out the medicine round were observed to provide medicines safely. They checked medication administration records (MAR) charts before preparing medication. The nurse spoke with the person and explained what they were doing. The nurse signed the MAR chart when the person had taken their medicines.

In the case of a PRN (as required) medicine, we noted that the nurse asked the person and acted on the person's wishes. We observed that the nurse recorded accurately if a person refused medicines and if a medicine had to be destroyed.

We saw that when medicines were administered covertly, a protocol was in place. This meant the medicine was hidden in food otherwise the person would not take it. We read a GP letter to the person's family and the service regarding covert administration.

The clinical or treatment rooms, one located on each floor, contained a medicine trolley that was secured to the wall and wall cabinets including a lockable inner cabinet for controlled drugs and a refrigerator. Daily temperature checks were carried out for both room and fridge temperatures. We saw that these had been done and were within the correct range.

We examined fire safety throughout the home. Procedures were in place to ensure people were safe if a fire were to occur. We saw each person had a personal emergency evacuation plan (PEEP) and that a central record was held in the event of an emergency. We saw that a home-specific fire risk assessment dated 2015 was in place and that the fire brigade had last conducted a visit in July 2015. The fire brigade placed requirements on the home to improve a small number of practices regarding fire safety, and the provider was able to show us evidence that these were complete, except for staff training. The training matrix showed 19% of staff had not received up to date training in fire safety.

Personnel files for ten of the newest staff that had commenced employment at Chiltern Grange Care Home included information related to appropriate checks of identification, previous employment history and conduct checks were completed before new staff commenced shifts. In addition, the home applied for and obtained Disclosure and Barring Service (DBS) criminal history checks and confirmed that new starters were not barred from working with people.

Agency staff were used by the provider to cover staff shortages. We saw that the provider requested employee profiles from their preferred supplier of temporary staff and that induction records were maintained to show that agency workers knew basic policies and procedures. For registered nurses, the provider maintained records of checks which showed the employee was still registered with the Nursing and Midwifery Council (NMC).

We checked the safety of hot water outlets like hand basins, bath tubs and showers. All of the necessary outlets had temperature regulating valves installed to ensure people

were protected from the risk of scalding. In addition, the maintenance person also completed monthly checks of the water temperature supply to show that the water did not exceed national safety guidelines. Checks and servicing in relation to equipment used in the home had been carried out to ensure their safety. We spoke with staff in the kitchen and the laundry; they all demonstrated appropriate knowledge of what to do if they could smell gas and how to shut gas off in an emergency.

People had call bells in their rooms to alert staff if they needed assistance. They said calls were answered within a reasonable time, although there could be a slower response in the mornings when staff were busy. Staff told us where people were not able to operate call bells they were checked at least hourly. Visits to a person's room to provide care such as personal care or repositioning were recorded in the person's room folder.

One person told us there was not enough staff working in the home. They told us they required two members of staff to help them with personal care. This meant when they pressed their bell for help, staff would acknowledge their request but would tell them they would come back when the staff were available. They told us they did not have to wait long, but that they were reluctant to ask for help because they were aware of how time consuming it was for staff. Another person told us they got up at 9 am each day but would prefer to get up earlier. They believed the reason this was not possible was due to there not being enough staff present to achieve this.

We examined the staffing rota for the week prior to the inspection. We were unable to decipher from the rotas whether the required staffing levels had been achieved. This was partly due to the number of hand written amendments. We discussed this with the manager who was in the process of introducing a new rota to provide a clearer overview. The provider carried out a dependency assessment which informed them of the required staffing numbers to meet the individual needs of people. Currently the home did not have sufficient permanent staff employed to meet the required staffing levels, and depended heavily on agency staff. The current number of vacancies at the time of the inspection was approximately nine staff. One person told us the impact of this was that they had to explain to the agency staff each time they visited, what their needs were. Staff told us "We have struggled with this problem." Another staff member told us that "Staffing is getting better." Currently the provider is looking to recruit to fill the current vacancies to ensure a full staffing quota is available to people. On the days of the inspection we observed an adequate number of staff on the premises.

Inadequate

Is the service effective?

Our findings

People told us they thought the staff were knowledgeable in how to carry out their roles. Two people told us the care was of a good quality. Another person said "The home is marvellous and the staff are very helpful."

The home's internal trainer had recently left and an interim trainer was in position. Part of the training and development of staff was the implementation of the Care Certificate. The Care Certificate is an identified set of 15 standards introduced in April 2015 that health and social care workers must adhere to in their daily working life. The previous trainer had highlighted in a handover document the problems they had encountered with the implementation and on-going teaching for the Care Certificate at Chiltern Grange Care Home. In part this was due to difficulties in carrying out observations of staff working and releasing staff from their duties to attend the training. Records showed that some new staff had started the training for the care certificate but none had completed it. For some staff this meant their training for the certificate had been on-going for four months. The training matrix identified that none of the new care assistants had completed the basic life support, moving and handling, fluid and nutrition or dementia modules. In addition, we looked at role specific 'induction schedules' which were forms where the date of each new starter's training was recorded and the staff member and trainer signed off. Each of the four versions of the form given to us by the provider was dated October 2011. The training recording records did not show that the subjects covered were in line with the contents of the training certificate and covered areas such as Duty of candour.

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

The provider supplied us with a supervision calendar to demonstrate which staff had participated in supervision sessions and when they occurred. We found that between January and March in 2015, no care assistants or registered nurses had received supervision meetings. In the same period, a small number of ancillary staff for example, housekeepers and kitchen staff had received supervision meetings. We saw a greater number of staff that provided care had documented supervision sessions in April 2015 and onwards, however 18 staff had received no supervision at all in 2015 up to the date of the inspection. The provider's supervision policy stated that "All support staff should have at least one formal supervision session of at least one hour duration every 2 months." This meant that the provider did not always provide appropriate support to staff to enable them to carry out their duties and facilitate development of their abilities.

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

Staff we spoke with had done some training on the Mental Capacity Act 2005 (MCA). A staff member we spoke with showed a good understanding of MCA principles. They said "I think the core principle is that we should not assume that people do not have capacity. I should not assume that (named person) cannot make decisions for herself." Another staff member told us MCA was about whether people could make decisions themselves or "if they need help with this." The staff member gave examples from practice. We saw an example of consent for the use of bedrails for a person who lacked capacity. Consent to the use of bedrails had been discussed with the person's family and a relative (who was closely involved in the person's care).

We saw a mental capacity assessment in a person's care plan. It indicated that the person did not have capacity. The assessment had been reviewed monthly. We saw a review that stated 'no changes in mental capacity assessment'. However, the assessment was not time or decision specific. The assessment should have addressed a specific decision such as consent to personal care. This was not in line with the MCA code of practice. The training matrix showed nearly a third of care staff had not completed the MCA training. Plans were in place for this to be carried out in the near future.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. A number of DoLS applications had been made to the local authority. This ensured where a person was being deprived of their liberty, this was assessed by the local authority to check it was proportionate and the least restrictive method was being used. The provider assured us staff always acted in people's best interest, however there were no documents available to us to demonstrate this. For example, where a person did

not have the ability to make a decision for themselves, the staff and where appropriate other professionals and family members agreed on a decision that was in the person's best interest.

We spoke with the home's administrator who deals with finance matters. The administrator had good knowledge of how to handle finance matters for people who did not have capacity to make decisions for themselves. The administrator was able to explain to us the purpose and function of enduring power of attorneys and a Court of Protection appointed deputy, which demonstrated the provider was acting on behalf of people under the powers of the Mental Capacity Act 2005 and other regulations. We were shown that (where the provider was aware of them existing), copies of the power of attorneys or other legal documents pertaining to people's finance were copied and kept securely on file.

People told us the food in the home was good. One person said "The food is edible and I never go hungry." People's food preferences were documented. This information included food allergies or specific cultural or religious requirements. We saw menus were appropriately displayed. People were able to place menu choices in advance and could change their selection about meals closer to the time of service.

People were supported with their hydration and nutritional needs. Where people required support with eating or drinking this was provided by staff. Where people were at 'higher risk' of malnutrition or dehydration their food and fluid intake was recorded. When asked, staff were unsure why food and fluid charts were kept for certain people and not others. We examined fluid charts for three people where there was a risk of dehydration. The records covered a nine day period of recording fluid intake and urine output for each person. Whilst the fluid intake charts showed day staff consistently recorded drinks and volumes the person consumed, recording of drinks on late shifts and night shifts declined or was not recorded at all. Documentation regarding people's urine output was not completed. This meant monitoring of people who were at a high risk of poor fluid intake leading to dehydrated not effective and placed people at risk of harm.

We carried out observations during the lunchtime period in the dining rooms on two floors. We also saw how people were supported with their meals when they remained in their rooms.

On one floor we saw there was little to no communication between staff and people during the lunch period. We observed a person fall asleep at the dining table; they were awoken 15 minutes later when the staff cleared the crockery. Another person was unable to manage their meal with a standard knife and fork and instead slowly used two fingers in an attempt to get food into their mouth. During this time we observed a nurse stood leaning against a counter eating a dessert, whilst it was clear people needed assistance.

On another floor we observed good interaction between staff and people, but again we saw one person unable to use a knife and fork and resorted to using their fingers to eat their cooked meal. They were offered no support by staff for 20 minutes. This meant people's dignity was not maintained and a risk to their nutritional intake was present.

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

We saw that the service made requests for speech and language therapy (SALT) and dietician assessments when a person's nutrition and hydration caused concern, for example as a result of swallowing difficulties. Care plans included a section on nutrition. We saw that care plan objectives included involvement of visiting professionals and had been reviewed at least monthly. However, we saw that for one person the changes to the consistency of the thickener used in their drinks to prevent choking had not been updated in their care records. This placed people at risk of harm if records related to nutrition and hydration had not been completed correctly or kept up to date.

The home used the malnutrition universal risk tool (MUST) to score and rate nutritional risks for every person. Documents showed one person had been assessed not to have been at risk of malnutrition. However, when we checked, the person had a sustained weight loss equalling a 13% overall weight loss in six months. This meant the actual score should have indicated a high risk for weight loss for this person. In the case of high risk weight loss or sustained weight loss, a dietician should have been invited to review the person's risk. This had not happened as the person was wrongly not assessed as at high risk. When we spoke to staff to ask about training in the use of the MUST tool, they advised that they had not been trained in its use. Training records showed approximately 6% of care and nursing staff had completed training on nutrition including

Inadequate

Is the service effective?

the use of the MUST tool. We checked the records related to people's weight on the first floor, these showed, eleven people had lost weight in the past month, while seven people had gained weight.

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

People were assisted to access the healthcare support they needed when they required it. A range of professionals were involved in assessing, planning, implementing and evaluating people's care and treatment. A nurse told us that the nurses in the home liaised with external professionals including the mental health team and the tissue viability nurse. We found that GPs came regularly to the home on Mondays for routine matters and reviews, and a GP was present seeing residents on one of the days of our inspection. We noted staff interaction with the GP which was person focussed, professional and informed by the person's wants and needs.

Staff used a handover meeting to relay information between shifts. On the nursing unit, we saw an example of a nursing handover sheet which covered the night staff handover to the day shift. Notes on individual care needs reflected how people had been cared for and any specific needs that had arisen during the night. For example, one person had not slept until 2am.

We recommend the service seek advice from a reputable source regarding the implementation of the MCA and DoLS code of practice.

Good

Is the service caring?

Our findings

People described the staff as caring, very helpful and supportive. One person told us "The staff are wonderful, they look after me beautifully and I love them all." Some staff knew people and their care needs well. They were caring and considerate in their approach to people. They spoke to people in a friendly but respectful way.

A person told us they were cared for "very well." Another person told us "There's a fantastic team of nurses." Two people described one staff member as "loving and caring" and another told us a member of staff stood out from the rest. When asked why they explained it was because they treated people well and they were very gentle in their approach.

We observed some positive interactions between staff and people who use the service. We saw people being spoken to discreetly when they needed assistance. We observed staff laughing and joking with people and having fun. We saw that staff listened to people when they were talking to them.

We saw that a person's care plan contained a personalised communication book developed by the speech and language therapy team. It contained guidance on communicating effectively with the person. A nurse we spoke with knew how to communicate with the person.

We observed examples of staff supporting people's privacy and dignity for example by knocking on doors and asking permission to enter. Staff ensured that doors were closed when personal care was given. We observed a member of staff assisting a person who was asking directions to their room. The person was holding the carer's arm as the carer walked at a suitable pace for the person. One staff member pointed out to us the need to "reassure and support" people who lived with dementia to any alleviate fear and confusion they may have.

Minutes of a recent relatives meeting highlighted an example of staff going beyond the call of duty. The minutes noted the relative stated: "They [staff member] had gone the extra mile" by escorting a resident to hospital after their shift concluded, and even stayed on until the family arrived at the hospital." This demonstrated a staff member's commitment to the person they were caring for and their family.

We observed the relationships that had been built between some people and some staff. For example, we saw a person who was due to return home after a respite care stay. They were asking for a particular member of staff. When the staff member was free, the person embraced them and said "Thank you." The staff member replied "I'll see you in (time of next stay)."

Staff we spoke with discussed the importance of supporting people's dignity and of family involvement in people's care, for example finding out about a person's preferences. Care plans documented people's preferences and consent to care.

Staff asked people about the care they required. For example, we saw one nurse ask people if they needed any medicines to relieve pain or discomfort. They explained to people what they were doing when carrying out their care and people responded positively to their approach.

One person had access to advocacy services. During the inspection their advocate was present. This service assisted the person to ensure their wishes and opinions were where possible listened to by the provider.

People's planned end of life care was considered by the home. When we checked on one floor, sixteen people had documented 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms on file. The forms showed a GP held crucial discussion with people and their loved ones about resuscitation and the potential lack of success if it was attempted. There were also end of life care plans where people's preferences if their state of health quickly deteriorated had been obtained and would guide their final care at the home.

Requires improvement

Is the service responsive?

Our findings

People told us they were included in the planning of their care but could not always make decisions and choices about how it was delivered. For example one person wanted to have their breakfast earlier than it was currently provided, another person wanted to get out of bed earlier than they were presently able to. They both felt they could not do this because of a lack of staff or staff were too busy.

We saw pre-admission assessments had been used and the ability to care for the person before they moved into the home had been assessed. This ensured that people's needs that might not be able to be met by the home had been considered in advance. There were also risk assessment tools that determined whether people were at risk of pressure ulcers, falls and malnutrition. We saw that where people could, they had signed to indicate they were aware of care plan content and had been involved in the construction of the documents. Relevant appropriate care plans were also contained in the folders. Examples for care plans we viewed included ones for how people liked their hygiene attended to, people's sleep preferences and night care methods, whether people had any pain and how staff would manage people's continence. Whilst permanent staffing recruitment and placement had potential impact on the ability to have keyworkers or named nurses for each person that lived at the home, we saw keyworker recording forms in the folders were sometimes left blank. This indicated that people's discussions with staff about their care were either not completed or failed to be recorded. In addition, the form which recorded discussions with any relatives was also sometimes blank.

Throughout the home, there was some signage and documents that told people how to make complaints. For example, after entering the front door, a sign on the wall pointed out that complaints could be made by anyone and how to initiate one if needed. In the reception area itself, there was a folder on a side table which also contained the information about how to make complaints.

The home's policy for complaints management was dated January 2011 and had not taken into account changes in legislation regarding complaints handling that came into effect on 1 April 2015. For example, people who complained had not always received a written acknowledgement after lodging the complaint, or a written letter of the outcome after an investigation. Documents related to one complaint had no attached investigation record another had no stated outcome. There was a 'monthly complaints monitoring and audit form' which was not always completed and saved in the folder with the actual complaints. However we saw no documentation to show that management analysis of trends or themes of complaints received had been completed or acted upon.

This is a breach of Regulation 16 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives had the opportunity to give feedback through the completion of a questionnaire. We were given the latest summary of questionnaires received. These were not dated, so we were unable to gauge how recent they were, but the operational manager told us they were recently completed possibly in September 2015. The home operated a system of sending out questionnaires randomly to people twice a year. The questions related to the care, food, environment, activities and how staff answered the telephone and responded to enquiries. 18 people had completed the questionnaire, but we were unsure how many respondents were people living in the home and how many were relatives. There were only two questions related to the care people received and these were directed towards relatives. For example, "How would you rate the quality of care your relative received?" and "Do you feel your relative is treated with dignity and respect?" Both had positive results.

Meetings were also held with residents and relatives and notes were taken from the content of the discussions. We looked at the discussion from the relatives' meeting held on 14 October 2015. At the meeting, one relative described out of the ordinary care provided by one of the staff members. Actions for the provider documented in the minutes from the meeting included improving communication between the care home and relatives, increasing the quality and quantity of activities and implementing a resident sign-out book.

Meetings were also documented as having been held with staff, although the frequency of these was sporadic. We saw meetings occurred with night staff on 16 September 2015 where infection control, documentation standards and staff training was discussed.

People were supported to take part in activities. The Home had two activities coordinators who organised daily activities for people. Activities for the week, including

Requires improvement

Is the service responsive?

weekends, were shown on a programme that was displayed in the reception area and distributed to people each Monday. These included puzzles, board games, arts and crafts, sing-along and painting. The home had a dedicated driver and access to a shared minibus; this meant that for two days a week people could go on trips to places of interest. For example, shopping in a nearby town. We observed activities being carried out by staff with people, including bowling and completing a jigsaw.

Requires improvement

Is the service well-led?

Our findings

One person told us "Generally speaking, the home isn't bad but it can be disorganised at times, and I have complained about it." This view was shared by a visiting relative.

The current manager of the home had commenced employment four weeks prior to the inspection. During the previous 14 months the home had been managed by two consecutive managers and during periods when there was no manager, the home was overseen by the regional manager and a project manager. Records showed that a minimum of 21 staff had left employment in the home since January 2015.

Furthermore, the provider has a legal duty to inform the CQC about changes or events that occur at the home. They do this by sending us notifications. During the inspection we were made aware of two safeguarding concerns the provider had failed to inform us of. They had also failed to notify us of the changes that occurred to the management of the home. In addition, we noted the provider's statement of purpose contained out of date information and had not been revised in line with the regulatory requirement. When we checked our central database to ascertain whether changes had been communicated to the CQC for the statement of purpose, we found no record of this being submitted by Chiltern Grange Care Home.

This is a breach of Regulation 12, Regulation 15 and Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Without an effective manager in place it was evident different aspects of the running of the home had not been monitored, and as a result improvements had not been made. For example, We looked at the prevention of Legionella in the water of the home. We saw that a Legionella risk assessment dated 5 June 2015 had been completed. This identified eight immediate actions to be taken to control the identified risks of Legionella. The document showed that none of these actions had been signed or dated as completed, and the responsible person was a home manager who no longer worked at the home. We also looked at the provider's last infection control audit dated 18 June 2015. Furthermore, there was no associated action plan to address points of concern in the infection control audit. In addition, the home's risk assessment for infection control was dated January 2014 and for another care home in the provider's group. We noted that the home did not have placement of alcohol gel dispensers for fast, location-based hand hygiene and that hand washing signs near relevant sinks used by staff were not in place. We saw that the assessment, monitoring and mitigation of the risks related to the health, safety and welfare of people and others in the home had not been completed regularly and in sufficient detail to protect people from harm.

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

The new manager was aware of the challenges the home currently faced. Together with the regional manager they were taking steps to improve the service. For example, they were hoping to increase the salaries of staff to improve staff retention. An increased stability of staff members they hoped would lead to more consistent care provision. They were also considering offering transport for staff to and from the local town to attract staff who may otherwise not be able to travel to the home. Other plans for improvement included the quality and quantity of the activities provided to people and an improvement in staff communication.

Audits that had been completed were reported to the regional manager each week. Once examined the audits were reported to the relevant senior manager within the company each month. Health and safety checks had been completed, servicing of equipment and testing of electrical equipment. There was a fire safety risk assessment in place and regular fire drills were carried out along with testing of the fire equipment. The home manager and the regional manager did checks by calling into the home at unexpected hours to observe practice.

The home did have a clear philosophy of care, and this was clearly set out in the statement of purpose and 'residents' handbook'. The provider aimed to create care homes where "…safety, security and high quality care is available to all service users". The staff we spoke with were honest and open as far as we could tell and were aware of the challenges faced by the provider in attempting to meet these aims.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

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 ensure the proper and safe management of medicines. 12 (1) (2) (g)

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 People who use services and others were not protected against the risk of abuse as not all staff knew how to respond to allegations or concerns of abuse. 13 (1) (2) (3) (4) (a) (b) (c) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider failed to provide receive such appropriate support and training to staff to enable them to carry out the duties they are employed to perform. 18 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The provider failed to meet people's nutritional and hydration needs. 14 (1)(2)(a) (b) (4)(a) (b) (c) (d)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints Effective systems were not in place regarding the receiving, recording, handling and responding to complaints. Regulation 16 (1)(2).

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 mitigate the risks relating to the health, safety and welfare of people living and staff working in the home. 17 (1) (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose The provider failed to notify the Care Quality Commission regarding changes to the location which affected their statement of purpose. 12 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 CQC (Registration) Regulations 2009 Notifications – notice of changes The provider failed to notify the Care Quality Commission regarding changes in management at the location. 15 (1) (a) (b) (c)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider failed to notify the Care Quality Commission regarding safeguarding incidents. 18 (1) (2) (e)(f)