Review of compliance

Chiltern Court Nursing Home	
Region:	South East
Location address:	Aylesbury Road, Wendover, Bucks. HP22 6BD
Type of service:	Care Home
Date the review was completed:	17th June 2011
Overview of the service:	Chiltern Court is a care home which provides nursing care for up to fifty-three older people. There are qualified nurses on duty at all times, supported by a team of carers and ancillary staff.

Summary of our findings
for the essential standards of quality and safety

What we found overall

We found that Chiltern Court was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out the review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews and because concerns were identified in relation to:

- Safeguarding people who use services from abuse

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 15 June 2011 and collected further documents from the home on 17 June 2011. We observed how people were being cared for, talked with people who use services, talked with staff, checked the provider's records, and looked at records of people who use services.

What people told us

One person told us they were well looked after by staff, who were very kind. We were told by another person that they were bored and had nothing to do. They said they didn't go out because there were not enough staff but they did enjoy the church service in the home every Tuesday.

People told us that staff mostly knock on their door but one person said that some staff didn't always knock.

We were informed by people that they felt safe in the home and people said if they were unhappy they would talk to one of the staff or the manager. One person told us they didn't know who to talk to if they had concerns.

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People were positive about the staff who worked in the service. They said staff were very helpful and always came quickly when they pressed their call bell. One person

told us they were well looked after but there wasn't always enough staff especially in the mornings.

What we found about the standards we reviewed and how well Chiltern Court was meeting them.

Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights

- Records did not always reflect peoples' individual needs in relation to their personal care or detail how risks would be managed and reviewed.

- Overall we found that Chiltern Court was not meeting this essential standard and we propose to take compliance action to address this concern.

Outcome 7: People should be protected from abuse and staff should respect their human rights

- Staff had attended safeguarding training but some staff did not have a good understanding of what to do or how to report or raise any concerns.
  The home had policies and procedures in place to inform staff how to report any actual or potential abuse, however these not all of these were accessible to staff.

- Overall we found that Chiltern Court was not meeting this essential standard and we propose to take compliance action to address this concern.

Outcome 9: People should be given the medicines they need when they need them, and in a safe way

- Chiltern Court was failing to protect people against the risks associated with unsafe storage and management of medicines.

- Overall we found that Chiltern Court was not meeting this essential standard and we propose to take compliance action to address this concern.

Outcome 12: People should be cared for by staff who are properly qualified and able to do their job

- There was a recruitment process in place, designed to ensure that people who use the service were cared for by suitable and appropriately qualified staff. The staff personnel files did not all contain information to show that these processes were consistently implemented.

- Overall, we found that Chiltern Court was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

- Staff were working excessive hours to ensure that staffing numbers remain at a safe level.

- Overall, we found that Chiltern Court was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

- People who use services benefited from a staff team who received regular supervision and were up-to-date with their training.

- Overall, we found that Chiltern Court was meeting this essential standard.

Outcome 17: People should have their complaints listened to and acted on properly

- The home had a complaints system in place so people usingf the service could make a complaint.

- Overall, we found that Chiltern Court was meeting this essential standard.

Outcome 20: Notifications of other incidences.

- People could not be confident that important events which affected their health, safety and welfare were reported to the Care Quality Commission so that appropriate action could be taken.

- Overall, we found that Chiltern Court was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

Outcome 21: Records

- Care records for people living in the home were stored securely. Some records were not accessible and could not be located promptly when needed.

- Overall we found that Chiltern Court was not meeting this essential standard and we propose to take compliance action to address this concern.

Action we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

What we found
for each essential standard of quality and safety we reviewed

Outcome 4:

Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:

- Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There were moderate concerns with outcome 4: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us

One person told us they were well looked after by staff, who were very kind. We were told by another person that they were bored and had nothing to do. They said they didn't go out because there were not enough staff but they did enjoy the church service in the home every Tuesday.

People told us that staff mostly knock on their door but one person said that some staff didn't always knock.

Other evidence

We looked at the records of people using the service. We saw that assessments were undertaken prior to people moving into the home and included an assessment of their needs and risk assessments.

There was information about people's dietary likes, dislikes and allergies, personal care needs, mobility and communication. In one file we looked at the person had specific, specialist needs; however the care plan detailing how these needs should be met were locked in the managers' office to which other staff did not have access.

Risk assessments were in place for mobility, tissue viability, nutrition, medication and falls. These were up to date and reviewed monthly. However some information within the care plans was different to the risk assessments. For example, in one care plan it stated that the person walked with support but the risk assessment

stated the person was fully mobile. In another file the care plan stated the person was of average build and weight, but the nutrition assessment stated that the person was obese. In the same file the care plan stated the person had developed Alzheimer's but the assessments stated they had no long or short term memory problems.
The conflicting information contained within the care plans and the assessments did not ensure that an accurate assessment of the person had been completed.

We saw recorded in one care plan that the person had developed a pressure sore and a plan of care had been put in place to manager this. The care plan stated that the wound must be checked daily and the dressing changed. The daily records made no reference to this. We were told the pressure sore had since healed but this had not recorded and the care plan had not been not updated to reflect this.

Care plans were evaluated monthly but did not always identify changes. For example, one person had a care plan in relation to nutrition and being weighed monthly. We saw that monthly weights had been recorded and the person had steadily lost weight, however the evaluation of the care plan stated there was no change.

Care plans made no reference to people's capacity and ability to make decisions.

It was not recorded in care plans that the person had been asked their preference in relation to having a male or female to provide personal care. We were told this question was not routinely asked but if a person requested a specific gender of staff to provide personal care then this would be provided.

We saw a 'Social and spiritual care' policy in place dated 1/12/10. This stated that "residents must be cared for by the same sex staff if they prefer and this must be documented on care plan". One person we spoke to was unaware they had a choice.

Staff completed records of the care they have provided on a daily basis. These lacked detail and did not provide any information about the person's mood state or the activities that the individual had undertaken throughout the day. For example we saw regular entries that stated the person had been settled in their room and all personal care had been provided. Many entries in the daily record notes were difficult to read and some where not legible.

Our judgement
Records did not always reflect peoples' individual needs in relation to their personal care or detail how risks would be managed and reviewed.
Overall we found that Chiltern Court was not meeting this essential standard and we propose to take compliance action to address this concern

Outcome 7:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:

- Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

There were moderate concerns with outcome 7: Safeguarding people who use services from abuse.

Our findings

What people who use the service experienced and told us

We were informed by people that they felt safe in the home and people said if they were unhappy they would talk to one of the staff or the manager. One person told us they didn't know who to talk to if they had concerns.

Other evidence

All staff spoken to confirmed they had received safeguarding training and would report abuse. This training had been delivered internally. Not all staff spoken to knew who to contact outside of the home, for example, the local authority safeguarding team or the Care Quality Commission. One staff member referred us to a poster in the staff room which was an elder abuse poster with a telephone number of who to contact.

One staff member had no understanding of her responsibility to report abuse and two staff told us they would not report an incident if one person hit another, as they did not recognise that as abuse.

We were not able look at the contents of the safeguarding training programme, staff personnel files, training or induction records as they were not accessible on the day of the visit. This information was collected from the home on Friday 17th June 2011. These confirmed that staff completed in-house Safeguarding Vulnerable Adults training every year. We were unable to establish the quality of the training provided

and whether the staff were suitably qualified to deliver the training.

Staff were unable to locate a copy of the local authority safeguarding policy and procedures. We were told that this was locked in the managers' office. The registered manager was not present on the day of the visit. Senior staff on duty were unaware of how to contact the area manager because he was new to the organisation and did not have a contact phone number for this person.

The senior staff understood what was meant by whistle blowing and we saw that organisational procedures and policies for safeguarding vulnerable adults and whistle blowing were in place.

We asked to look at a staff handbook and to see if these policies were accessible to all staff but the handbook was not accessible on the day and was locked in the managers' office.

Our judgement

Staff had attended safeguarding training but some staff did not have a good understanding of what to do or how to report or raise any concerns.
The home had policies and procedures in place to inform staff how to report any actual or potential abuse, however not all of these were accessible to staff.
Overall we found that Chiltern Court was not meeting this essential standard and we propose to take compliance action to address this concern

Outcome 9:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
- Will have their medicines at the times they need them, and in a safe way.
- Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

There are major concerns with outcome 9: Management of medicines

Our findings

What people who use the service experienced and told us
We did not receive any feedback from people using the service about management of their medicines.

Other evidence

We saw procedures in place on managing people's medicines. Staff training records showed that they received training on safe administration.

Care plans contained information about medication, which included risk assessments for medicines and creams.

We found seven large Monitored Dosage system bags and one plastic bag full of medicines, creams and lotions stored in an unlocked bedroom. There was no record of these medicines received into the home which were delivered on Monday 13th June 2011. We were informed that the bedroom was normally kept locked. We have asked the provider to take urgent action to address shortfalls were told that the bags contained a full month's supply of medicines for people using the service.

We have asked the provider to take urgent action to address shortfalls in the safe storage of medicines.

We examined the procedures for the safe administration and storage of controlled medicines. The storage facilities were in line with legal requirements and the

controlled drugs register was fully completed with two signatures for each transaction.

Medication administration records were in good order and showed that medicines were being dispensed in line with the doctors' instructions.

Our judgement

Chiltern Court Care Home was failing to protect people against the risks associated with unsafe storage and management of medicines.

Overall we found that Chiltern Court was not meeting this essential standard and we propose to take compliance action to address this concern.

Outcome 12:

Requirements relating to workers

What the outcome says

This is what people who use services should expect.

People who use services:

- Are safe and their health and welfare needs are met by staff who are fit, appropriately qualified and are physically and mentally able to do their job.

What we found

Our judgement

There are minor concerns with outcome 12: Requirements relating to workers

Our findings

What people who use the service experienced and told us

People were positive about the staff who worked in the service. They told us they were very kind and at staff were helpful and very kind.

Other evidence

Staff files were not available on the day of the visit. We collected this information from the home on Friday 17th June.

We looked at the recruitment files for six staff who work at the service. In one file we saw that the persons' visa expired on 30/09/2010 and there was no evidence of their present immigration status.

In a second file we saw that the person commenced employment in 2006. We were unable to find references in this file. We did find a competency record for a course undertaken in 2000 and a certificate of good moral character from a university dated 1999.

In another file the person had two character references from friends and we were unable to find a reference from a previous employer.

In a further file we saw that the person had commenced employment in the home in 2007. We were unable to find any references in this file but we did find a certification letter from a previous employer dated June 2006. There was a further certification of employment from another previous employer dated April 2006.

All files contained a photograph of the person, an application form (with gaps to work history explored), confirmation of an enhanced CRB clearance, proof of identification and a job description outlining main roles and responsibilities and terms and conditions of employment.

Our judgement

There was a recruitment process in place, designed to ensure that people who use the service were cared for by suitable and appropriately qualified staff. Staff personnel files did not all contain information to show that these processes were consistently implemented.

Overall, we found that Chiltern Court was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

Outcome 13: Staffing

What the outcome says

This is what people who use services should expect.

People who use services:

- Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

There are minor concerns with outcome 13: Staffing

Our findings

What people who use the service experienced and told us
One person told us they were well looked after but there wasn't enough staff especially in the mornings.

Other evidence
We looked at staff rotas. These showed that there were care four staff on each floor during the day and one nurse. During the night there were two nurses and three care staff.

The rota showed that staff often work long days of twelve hour shifts and we saw some staff were working excessive hours in conjunction with their study days. For example one staff member worked seven long days before having a day off. Another staff worked five long days followed by a night shift and then a day off.

A third staff member had worked a long day followed by two study days at college, followed by three long days, one day off, another two study days, five long days, two study days, one long day, one day off and three long days.

Staff told us they felt the levels of staff cover were right for people's needs.

Our judgement
Some staff were working excessive hours to ensure that staffing numbers remained at a safe level.

Overall, we found that Chiltern Court was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

Outcome 14:
Supporting workers

What the outcome says

This is what people who use services should expect.

People who use services:
- Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

The provider is compliant with outcome 14: Supporting workers

Our findings

What people who use the service experienced and told us
We did not receive any feedback from people using the service about this standard.

Other evidence
Staff files were not available on the day of the visit. We collected this information from the home on Friday 17th June.

Staff confirmed that an induction was in place and we saw completed induction programmes in the files we looked at.

We looked at the training records for six staff and saw that people had received mandatory training which included Moving and Handling, Infection Control, Fire Safety, Safeguarding Vulnerable Adults and Basic Food Hygiene training. This training had been provided internally.

We looked at staff supervion records which confirmed staff received formal supervision. Some carers we spoke to did not understand what was meant by formal supervision and were unable to confirm if they had received 1: 1 support.

Staff told us the manager was accessible and approachable and responded to issues raised.

Our judgement
People who use services benefited from a staff team who received regular

supervision and were up-to-date with their training.
Overall, we found Chiltern Court was meeting this essential standard.

Outcome 17: Complaints

What the outcome says

This is what people should expect.

People who use services or others acting on their behalf:

- Are sure that their comments and complaints are listened to and acted on effectively.
- Know that they will not be discriminated against for making a complaint.

What we found

Our judgement

The provider is compliant with outcome 17: Complaints

Our findings

What people who use the service experienced and told us

We did not receive any feedback from people using the service about this standard.

Other evidence

Information in relation to complaints was not accessible on the day of the visit. We collected the information on Friday 17th June 2011.

There was a written complaints procedure. This explained to people their right to make a complaint. It also stated how complaints would be dealt with and the timescales involved.

We were provided with monthly complaints monitoring forms from January 2011 to June 2011. These showed the number of complaints received each month, the reason for the complaint and the action taken. The monthly monitoring sheets did not always provide us with information about whether the complaints had been responded to within timescales and whether the complaints had been resolved.

Our judgement

The home had a complaints system in place so people using the service can make a complaint.

Overall, we found Chiltern Court was meeting this essential standard.

Outcome 20:
Notification of other incidents

What the outcome says

This is what people who use services should expect.

People who use services:
Can be confident that important events that affect their welfare, health and safety are reported to the Care Quality Commission so that, where needed, action can be taken.

What we found

Our judgement

There are minor concerns with outcome 20 Notification of other incidences

Our findings

What people who use the service experienced and told us
We did not obtain any direct feedback about this outcome from people using the service.

Other evidence
Staff told us that any incidents of sudden death, serious injury, any injury or aggression by one person to another would be reported. We were told that the internal system for dealing with notification forms was for the administrator to send them to the organisations quality advisor. The quality advisor would then be responsible for sending the notification to the Care Quality Commission.
Copies of notifications were not accessible on the day of the visit. We collected this information on Friday 17th June 2011.
We collected six notifications from the home. Two of these were not fully completed and did not provide us with essential information, for example the cause of death and recent safeguarding alert had not been received by the Commission.

Our judgement
People could not be confident that important events which affected their health, safety and welfare were reported to the Care Quality Commission so that appropriate action could be taken.

Overall, we found that Chiltern Court was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

Outcome 21:
Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:

- Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
- Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

There are moderate concerns with outcome 21: Records

Our findings

What people who use the service experienced and told us
We did not obtain any direct feedback about this outcome from people using the service.

Other evidence
People's records were stored securely in locked filing cabinets to comply with the Data Protection Act 1998.
Staff personnel files, information about complaints, the local authority safeguarding policy, a plan of care for one person and notifications were stored in a locked office to which no one in the home had access. Some of this information was essential for staff to be able to meet the needs of people using the service.

Our judgement
Care records for people living in the home were stored securely. Some records were not accessible and could not be located promptly when needed.
Overall we found that Chiltern Court was not meeting this essential standard and we propose to take compliance action to address this concern.

Action
we have asked the provider to take

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:

- Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
- Other records required to be kept to protect their safety and well being are maintained and held securely where required.

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	**21**	Outcome 12 : Requirements relating to workers
	Why we have concerns: There was a recruitment process in place, designed to ensure that people who use the service were cared for by suitable and appropriately qualified staff. Staff personnel files did not all contain information to show that these processes were consistently implemented.	
Accommodation for persons who require nursing or personal care	**22**	Outcome 13: Staffing
	Why we have concerns: Staff were working excessive hours to ensure that staffing numbers remained at a safe level.	
Accommodation for persons who require nursing or personal care	**18**	Outcome 20: Notifications of other incidents
	Why we have concerns: People could not be confident that important events which affected their health, safety and welfare were reported to the Care Quality Commission so that appropriate action could be taken.	

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	**9**	Outcome 4: Care and welfare of people who use services
	How the regulation is not being met: Records did not always reflect peoples' individual needs in relation to their personal care or detail how risks would be managed and reviewed.	
Accommodation for persons who require nursing or personal care	**11**	Outcome 7: Safeguarding people who use services from abuse
	How the regulation is not being met: Staff had attended safeguarding training but some staff did not have a good understanding of what to do or how to report or raise any concerns. The home had policies and procedures in place to inform staff how to report any actual or potential abuse, however not all of these were accessible to staff.	
Accommodation for persons who require nursing or personal care	**13**	Outcome 9: Management of Medicines
	How the regulation is not being met: Chiltern Court Care Home was failing to protect people against the risks associated with unsafe storage and management of medicines.	
Accommodation for persons who require nursing or personal care	**20**	Outcome:21 Records
	How the regulation is not being met: Care records for people living in the home were	

	stored securely. Some records were not accessible and could not be located promptly when needed.

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Adult Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
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