

# Coate Water Care Company (Church View Nursing Home) Limited

## Chapel House Care Centre

### Inspection report

Horton Road  
Gloucester  
Gloucestershire  
GL1 3LE

Tel: 01793821200  
Website: [www.coatewatercare.co.uk](http://www.coatewatercare.co.uk)






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### Ratings

#### Overall rating for this service

Requires Improvement 

Is the service safe?	Good 
Is the service effective?	Requires Improvement 
Is the service caring?	Good 
Is the service responsive?	Requires Improvement 
Is the service well-led?	Requires Improvement 

# Summary of findings

## Overall summary

We inspected Chapel House Care Centre on the 26 January and 1 February 2017. Chapel House Care Centre is a residential and nursing home for up to 41 older people. Many of these people were living with dementia. 15 people were living at the home at the time of our inspection. This was an unannounced inspection.

We last inspected in July 2016 and found that the provider was not meeting a number of the regulations. We found that people did not consistently receive safe care and treatment, because staff had not always administered their medicines as prescribed. Additionally staff did not have access to training and support. People did not have access to person centred care and stimulation which would benefit their wellbeing. The provider did not have effective systems to monitor and improve the quality of service people received. Following our inspection in July 2016, the service entered Special Measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. We imposed a number of positive conditions on the registration of the location following our July 2016 inspection.

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 demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

At our inspection on 26 January and 1 February 2017, there was a newly appointed registered manager in post who had been in post since September 2016. 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.

The provider had implemented systems to monitor and improve the quality of service people received. Some of these systems had been used to drive improvements around the management of medicines. However some systems had only recently been implemented and therefore it was difficult to ascertain the impact they had on driving the quality of the service. People, their relatives and staff spoke positively about the improvements made at Chapel House since our last inspection. Relatives told us they felt their views were now being listened to and acted upon.

People and their relatives were generally positive about the home. They felt safe and well looked after. People enjoyed the food they received in the home and had access to food and drink. People and their relatives felt activities had improved; however activities were not always tailored to people's interests and hobbies. Care staff did not always provide meaningful engagement to people living with dementia.

People's care and risk assessments had been reviewed and were now reflective of their needs. Care

assessments give care staff and nurses clear information in relation to people's needs. People's care information was not always stored securely; however the director of operations took immediate action in response to our concerns.

Staff were deployed effectively to ensure people's basic needs were met and kept safe. All staff had received training to meet people's healthcare needs. Staff felt supported, however while staff had received supervision (one to one meeting) with the registered manager, they had not received appraisals and no assessments of their competency had been carried out. However this had been identified by the provider and there was a clear plan of action in place.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Care Quality Commission (Registration) Regulation 2009. You can see what actions we told the provider to take at the back of the full version of this report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good ●

The service was safe. People now received their medicines as prescribed. Nursing staff accurately recorded the support they had given people around their medicines and any errors were identified and responded to immediately.

Staff were deployed within the service to ensure the safety of people and protect them from risk. The management had recruited a number of permanent staff to ensure safe staffing levels.

Staff knew the risks associated with people's care and had guidance to manage them. People felt safe, and staff understood their responsibilities to protect people from abuse.

### Is the service effective?

Requires Improvement ●

The service was now starting to be effective. The service had started a system to ensure staff had access to one to one support and were implementing a new staff observation system; however these were not yet in place. People were supported by staff who had access to the training they needed to meet people's needs.

People received support to meet their nutritional needs and had access to plenty of food and drink. People were supported to make choices and staff had some knowledge in relation to the Mental Capacity Act 2005.

People were supported to attend healthcare appointments. Staff followed the guidance of external healthcare professionals.

### Is the service caring?

Good ●

The service was caring. People were supported to spend their days as they choose. Staff respected people and treated them as equals.

Staff knew people well and understood what was important to them such as their likes and dislikes. People were treated with dignity and respect.

### Is the service responsive?

Requires Improvement ●

The service was not always responsive. People did not always have access to activities which were personalised to their hobbies and interests. People did not always receive their care in a way which was in accordance with their personalised needs.

People's care assessments were now current and reflective of their needs.

The provider and registered manager responded to complaints and people and their relatives felt confident they could raise concerns to the registered manager.

**Is the service well-led?**

The service was starting to be well-led. The registered manager and provider had implemented a new quality assurance system however they had not all been in place long enough to evidence how they drive improvements within the service and maintain consistency.

The views of people and their relatives were now being sought and acted upon.

People, their relatives and staff spoke positively about the registered manager and the improvements they had noticed at the service since their appointment.

**Requires Improvement** 

# Chapel House Care Centre

## **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 was 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 the 26 January and 1 February 2017 and was unannounced. The inspection team consisted of two inspectors and a specialist advisor.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the service. This included notifications about important events which the service is required to send us by law. We also spoke with two healthcare professionals and both the local authority and clinical commissioning group commissioners about the service.

We spoke with five people who were using the service and with four people's relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also spoke with 13 members of staff which included three care staff, two activity co-ordinators, an administrator, a maintenance worker, a domestic worker, the home's chef, the clinical lead, registered manager, operations manager and operations director working on behalf of the provider. We reviewed six people's care files, care staff training and recruitment records and records relating to the general management of the service.

# Is the service safe?

## Our findings

At our last inspection in July 2016, we found people did not always receive their medicines as prescribed. People's prescribed medicines were not always stored in accordance with the manufacturer's guidelines. These concerns were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach had been continued from our inspection in March 2016. Due to this breach and other concerns, a positive condition (a positive condition is an instruction we place on the provider's registration which they must follow) was imposed on the provider in relation to the management of people's prescribed medicines. At this inspection we found effective action had been taken.

Nursing staff including agency nurses were keeping an accurate record of when they had assisted people with their prescribed medicines. For example, nursing staff signed to say when they had administered people's prescribed medicines and kept a record of prescribed medicine stocks and when they had opened people's prescribed medicines. Where gaps in recording had been identified by nursing staff, appropriate action was being taken to ensure people had received their medicines as prescribed.

People's medicines were stored in accordance with manufacturer's guidelines. Nursing staff recorded the temperature of the room where the medicines were stored in. These recordings showed the temperatures were within the manufacturers recommended range. People's prescribed medicines were stored securely and the clinical lead had taken action to reduce the amount of surplus prescribed medicines they kept stored within the service. This meant the risk of people's prescribed medicines being inappropriately used was reduced.

People were supported in a calm and patient manner with their prescribed medicines. For example, we observed one nurse assisting a person with their prescribed medicines. They took time to discuss what the medicines were for and the importance of taking them. Once the person was happy to take their medicines, the nurse ensured the person took their medicines before signing to say the medicines had been administered.

People and their relatives told us they felt the home was now safe. Comments included: "I don't feel I have to come in anymore, it felt like I was working seven days a week. I know mum is safe now"; "I feel safe here, I have no problems with that" and "I think the home is safe now."

People were protected from the risk of abuse. Care staff had knowledge of types of abuse, signs of possible abuse which included neglect, and understood their responsibility to report any concerns promptly. Staff told us they would document concerns and report them to the registered manager, or the provider. One staff member said, "I wouldn't hesitate to go to the manager if I saw anything concerning." Another staff member added that, if they were unhappy with the manager's or provider's response they would speak to local authority safeguarding or the CQC. They said, "If I had tried the manager and I wasn't happy I would go to CQC or the local council (safeguarding team). I'm confident about raising any concern". In the home's staff room there was clear information for care and nursing staff to follow regarding safeguarding and the providers whistle blowing policy.

The registered manager and provider had raised and responded to any safeguarding concerns in accordance with local authority safeguarding procedures. Since our last inspection the service had ensured all concerns were reported to local authority safeguarding and CQC and acted on.

People were kept safe from hazards in the environment because the maintenance person had robust checks in place to ensure any risks or repairs needed were identified quickly and actioned. There were regular fire drills and legionella and water temperature checks. The maintenance person was also responsible for ensuring new staff had a fire safety induction. An external environment health company had been invited in to undertake an assessment and any suggestions they had put forward such as obtaining documentation regarding the layout of the building and increasing number of legionella checks per year had been accepted and actioned.

People were protected from the risks associated with their care. Staff had clear guidance regarding assisting people with their mobility needs, and concerns relating to pressure area care. For example, one person's risk assessments provided clear guidance on how staff should assist them to move safely, including the equipment they needed to ensure the person was safe and comfortable. Where people required assistance to reduce the risk of developing a pressure sore, staff had clear guidance to follow and understood the importance of following these guidelines. For example, one member of staff told us how they followed guidance to ensure people's pressure area needs were met. They also explained how they would involve local tissue viability nurses if they required further support and advice.

People were assisted with their mobility in a safe and effective manner. For example, we observed two care staff effectively transfer a resident from wheelchair to an arm chair. The staff spoke with the person throughout the movement and gave them reassurance. This ensured the person was comfortable throughout.

People and their relatives told us there was enough staff deployed on a daily basis to meet people's needs. Comments included: "I feel there are more staff around now, I have no concerns"; "I am happy, staff are around when I need them" and "I think it has improved."

Staff told us there were enough staff deployed to assist them to meet people's needs. Comments included: "I am happy now. We have a really good staff team now. We're more organised I feel the place is safe now"; "We have enough staff to meet people's needs" and "I think there are enough staff to meet people's needs."

Since our last inspection in July 2016 the provider had recruited a number of care staff and nursing staff. Care staff spoke positively about this change. One staff member told us, "It is going so much better now. Now we have our own staff, a real good team. We never feel rushed and we have the time to assess people every morning. Everything is in control and the night staff are helping out too". Additionally one healthcare professional provided positive feedback regarding the consistency of nursing staff and the positive impact it had on communication. They told us, "I think the service has improved in the last three months, which I perceive is due to more permanent nursing staff. I had concerns when I first started caring for these patients in 2015, because of the lack of continuity of staff. We now find more continuity of care which is better for our patients."

Records relating to the recruitment of new staff showed relevant checks had been completed before they worked unsupervised at the service. These included employment references and disclosure and barring checks (criminal record checks) to ensure staff were of good character. We discussed recruitment with the registered manager, as for one member of staff they were currently recruiting they had not sought a reference for a recent role they had with another care provider. This shortfall was acted on immediately, and



the registered manager was checking all recruitment to ensure staff were of good character before they started working at Chapel House Care Centre.

## Is the service effective?

### Our findings

At our last inspection in July 2016, we found that staff did not always have the skills they needed to meet the needs of people living in Chapel House Care Centre. This concern was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach had been continued from our inspection in March 2016. Due to this breach and other concerns, a positive condition (a positive condition is an instruction we place on the provider's registration which they must follow) was imposed on the provider in relation to the skills and support of staff. At this inspection we found effective action had been taken to meet the regulations; however there was still room for improvement to ensure staff were effectively supported, developed and skilled.

Whilst staff told us they felt skilled to carry out their role, the registered manager and representatives of the provider had not carried out competency assessments of staff to identify their individual training and support needs. Some staff recently employed by the provider had worked in other adult social care establishments; however no assessments had been done to establish if the provider or registered manager was happy with staff skills. This meant at present the service did not always have systems in place to ensure the competency of staff working at Chapel House Care Centre. However a manager from another home owned by the provider shared with us competency assessments which were being implemented in all of the provider's homes. These assessments focused on areas such as infection control, care recording and person centred care.

People were supported by staff who had access to supervision (one to one meetings with their line managers), however not all staff had yet received an annual appraisal. Staff told us they had received at least one supervision since our last inspection and since the new registered manager has been in post. Supervisions focused on staff views and needs. The registered manager also used supervisions in response to performance issues or concerns. Staff felt these meetings had been positive. Comments included: "I have had a one to one meeting with the manager, it was useful" and "I can go straight to the manager if I'm concerned. I didn't feel like that before." Whilst staff had received supervision, no staff had currently received an appraisal (a meeting which discusses staff development goals). A number of staff had recently been employed and had not worked at the service for 12 months, however staff that had been employed longer than this time had not had an appraisal. The registered manager stated they planned to complete appraisals once competency assessments had been completed. A number of staff had recently been employed and had not worked at the service for 12 months, however staff that had been employed longer than this time had not had an appraisal. We were assured that the provider and registered manager had clear plans to enable their staff to be trained and supported as well as have access to professional development in the future.

People were supported by staff who had access to the training they needed to meet people's needs. People and their relatives mainly spoke positively about care and nursing staff within the home. For example one relative told us, "Can't fault them (staff). They are much better." Some relatives however felt that whilst staff training had improved they still had concerns that not all staff were knowledgeable about their relatives individual needs. For example, one relative felt care staff did not always identify the triggers of their relative's

behaviours or needs.

Staff told us they felt training within Chapel House had improved and that they had access to the training they needed. Comments included: "I have the skills I need" and "I think regarding my job, yes I have all the training I need. I think I manage well." The registered manager had ensured that all staff had completed training which had been assessed as mandatory by the Director of Operations for the provider. The Director of Operations discussed with us the training staff had received and their plans to set up a provider learning academy for staff at Chapel House and other services owned by the provider. This would help to ensure staff had the additional training they needed to assist people with a range of conditions, such as Parkinson's. The registered manager told us how they were planning to build on the training staff received in these areas.

Staff told us they felt able to access additional training and were looking forward to developing their skills. For example, one member of care staff told us, "I feel I am able to request training, I have asked to do my NVQ (qualification in adult social care), which they have promised me, I hope it's okay." One nurse spoke positively about the support they had received from the Director of Operations to develop and around key areas of knowledge such as Deprivation of Liberty Safeguards.

People's consent and agreement was asked for by staff before they delivered their care. We observed on many occasions staff asking people if they were happy for staff to support them with specific tasks. For example, when staff assisted one person with their nutritional needs, they asked if they were happy to have support. Staff were aware of the Mental Capacity Act 2005 and the principles that underpin this. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff spoke about the Mental Capacity Act and how they assisted people with their choices. One member of staff told us, "We give lots of patience. Give them the support, time and encouragement they need. We always respect the person and never force or abuse them. For example (one person) we show them the options. They like toast; however we always offer them a choice."

The registered manager, provider and representatives of the provider ensured where someone lacked capacity to make a specific decision, a mental capacity assessment and if necessary a best interest assessment was carried out. For one person a best interest decision had been made as the person no longer had the capacity to understand the risks to their health if they were to leave the service unsupervised. The provider made a Deprivation of Liberty Safeguard (DoLS) application for this person. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People and their relatives told us they enjoyed their food. Comments included: "The food here is excellent", "I really enjoy the food" and "The food is good".

Meal times were calm and relaxed. Most people ate in the dining room but some preferred to eat sat in the adjoining room. Staff gave people the option for where they would like to have their meal. People were given a choice of three meal options at the beginning of the meal. There was a menu on each of the dining tables. If someone declined the options on offer then the chef would prepare whatever the person wanted as long as it was available. Where people needed assistance with eating staff supported them in a dignified way. They sat down with the person and engaged with them throughout.

The chef was knowledgeable about the needs of the people and showed us how they kept a record about their likes and dislikes. This included special diets such as diabetic diets or gluten free. The chef said that people can "have what they want within reason." There were snacks available for people throughout the day with squash and hot drinks set out to be used when people requested them. Throughout the morning we saw that staff were regularly offering people drinks and snacks.

People had access to health and social care professionals. Records confirmed people had access to a GP, dentist and an optician and could attend appointments when required. People's care records showed relevant health and social care professionals were involved with people's care. For example, records of appointments with healthcare professionals were also scanned onto the services computerised care planning system to ensure information was stored safely and securely.

## Is the service caring?

### Our findings

People and their relatives had positive views on the caring nature of care staff. Comments included: "The staff here are all lovely"; "The staff seem genuine and caring. The atmosphere has changed and people seem happier"; "This is their home, they do things for themselves. The girls love her to bits and she loves them" and "It is a caring place."

Care staff often interacted with people in a kind and compassionate manner. Care staff adapted their approach with people according to their communication needs. For example, care staff assisted one person with their mobility; they discussed with them how they were going to be assisted and where they were going. The person was happy throughout and afterwards asked for a cup of tea. One member of care staff respected their request and gave them a cup of tea.

Care staff took time to talk with people about their days or current affairs. For example, we observed one member of staff engage a person in conversation about the new president of the United States. The conversation was person centred and the person clearly enjoyed talking to the member of staff.

Staff spoke to people as an equal and supported them to maintain their independence. For example, we observed one member of care staff assisting a person with their nutritional needs. The person's needs and ability varied on a daily basis. The member of care staff explained how sometimes they needed to support the person fully, and other times the person could assist themselves independently. The staff member told us how they assessed the person on a daily basis to ensure their nutritional needs were met. We observed the staff member take time to sit with the person and encourage them to enjoy a drink and some biscuits.

Care staff knew the people they cared for, including their likes and dislikes. When we discussed people and their needs with staff, most confidently spoke about them. For example, one care staff member was able to tell us about one person, including how they liked to spend their days and the things which were important to them at tea time, such as a small alcoholic drink with their lunch. The person told us they enjoyed their daily drink and that they generally enjoyed life within the home.

People were able to personalise their bedrooms. One person had items in their bed room which were important to them, such as pictures of people important to them. Staff respected the importance of people's bedrooms. They ensured people's bedrooms were kept clean and knocked on bedroom doors before entering. Staff used a monitoring system at night, which alerted staff to people who walked with purpose at night and were at risk of falling. Staff told us this enabled them to protect people from harm and helped staff ensure people were safe without disturbing their privacy.

People were treated with dignity and respect. We observed care staff assisting people throughout the day. One person was being cared for in bed. Staff regularly checked on this person. They always knocked on the person's door and introduced themselves. They clearly asked the person if they required any assistance. All staff were aware of the person's needs and spoke positively about respecting the person. One member of staff said, "Every time we assist them, we make sure it's private. They're quite unwell so we keep an extra eye

on them."

People were supported to make advanced decisions around their care and treatment. For example, one person was asked for their views of where they would wish to be treated in the event of their health deteriorating. The person, with support from their family had decided they wished to go to hospital and have any treatment which would sustain their life. Another person had made a decision with their family that they did not wish to be resuscitated in the event of cardiac arrest, and this had been clearly recorded on a Do Not Attempt Resuscitation form.

## Is the service responsive?

### Our findings

At our last inspection in July 2016, we found that people's needs and the support they received were not always accurately recorded. Where people's needs had changed, their care records did not reflect this. This concern was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach had been continued from our inspection in March 2016. Due to this breach and other concerns, a positive condition (a positive condition is an instruction we place on the provider's registration which they must follow) was imposed on the provider in relation to the management of the service and people's care records. We found since our last inspection improvements had been made in relation to people's care records.

However, we found that people did not always benefit from effective stimulation, or received care which was personalised to their needs. While some improvements had been made there was still room for development.

The care and support people received was not always personalised to their physical needs. For example, a number of people were having aspects of their care and treatment recorded such as their food and fluid intake and personal hygiene support requirements even though no individual risks or a therapeutic need had been identified. We found that three people's fluid intake was being monitored on a daily basis because of risk of dehydration. While care staff knew how much fluid each person needed based on their needs, these targets were not consistently being met. There was not always a clear indication of the action being taken. We discussed this with the director of operations and the registered manager who informed us they would be reviewing the fluid targets for people with their GP.

Another person was having their personal hygiene needs monitored. We identified that these records did not always reflect the support the person needed and did not provide care staff with clear information. One member of care staff told us, "They are sometimes independent, so we don't always know what has happened." Another member of staff told us they did not always understand why they were recording aspects of people's daily care, such as fluid intake, particularly where people were eating and drinking well independently. We discussed this with the registered manager and director of operations. They informed us that a full range of monitoring is in place to ensure good recording practices are embedded with the staff team. While this practice is in place, it meant that records relating to the care and support of people was not always personalised to their needs.

People and their relatives told us that since the last inspection there had been an improvement in relation to activities and events; however people and their relatives felt there were still not enough personalised activities for them to enjoy. Comments included: "The activities have improved although I think there is still some room for improvement"; "I spend the day having meals and watching TV, they play ball games a bit silly really" and "I think it's better, they go out for coffee now which is better."

Whilst we saw some very meaningful interactions between a few staff and people overall we observed that care staff did not always engage with people and people were not always provided with activities which

were meaningful to them. Throughout the first day of our inspection we noted that the television in both lounges was left on, often without people watching them. People often went some time without positive stimulation from staff which could benefit their wellbeing. For example, in one lounge, care staff had time to provide one to one support to people, however whilst care staff promoted their nutritional needs, they did not provide stimulation or engage with people which would promote their sense of wellbeing.

Whilst people's care plans provided clear information regarding their health needs and contained a basic social history profile for each person, there was not always a detailed life history of the person or a record of their interests or hobbies. This meant staff did not always have the information to provide positive, meaningful, person centred stimulation. For example one person expressed interest in outdoor hobbies which included watching birds. They said, "I would like to have a pair of binoculars so I could watch the birds".

These issues were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However since our last inspection, Chapel House had employed two activities coordinators. Both the activity co-ordinators told us they were getting to know people and were aiming to complete a person centred activities profile and this is the document for each person. One activity co-ordinator told us, "I'm going around and speaking to people, identifying what they like." For example one person liked cars and so they made sure this person had lots of reading material about cars. The activity co-ordinators had a clear plan of how they wished to develop activities and promote the wellbeing of people living at Chapel House. They told us they were looking at providing physical activities and using the home's garden. They discussed trips out they had organised and the positive impact this had on people. They said, "A change of scenery can be really important." They had plans to link with a sports development programme and Age UK and were looking to promote cross working with other organisations in the community to promote the wellbeing of people at Chapel House Care Centre. There were various activities available including crafts and cake decorating. The activities coordinators told us that they made sure they spent one to one time with people as well as organising group activities. During our inspection we saw them talking with people about their interests and playing card games on a one to one basis.

People's care needs were documented in their care plans. People's care plans included detail on the support each individual needed which included support with their mobility, medicines, personal hygiene, communication and nutrition. People's care plans were detailed and updated when people's needs changed. For example one person's needs had changed regarding the emotional support they required, this was clearly documented to ensure staff had current advice to follow. People's care plans contained detailed information for care and nursing staff to follow and provided them with step by step guidance on how they were to assess the individual person's needs.

People's care plans were being reviewed on a monthly basis. Nursing staff reviewed all aspects of their care to ensure the care plans were current and reflective of their needs. Where changes had been identified these were clearly recorded. For example, one person's health had deteriorated prior to the inspection and the support they required was clearly recorded.

The director of operations and registered manager had implemented a 'resident of the day' system. This meant on one day, all staff in the home, including care staff, catering staff, domestic staff and nursing staff would focus on this person. The person and their family would be involved in the day and their views sought. The registered manager told us this enabled them to ensure people's care needs were being met and that information was current. Staff spoke positively about this process and how it put the person at the centre of



their care.

People's relatives told us they were informed of any changes to their relative's needs or any incidents. One relative told us, "I know if anything happens they will ring me. The nurses do ring me, there is no hidden agenda." People's care records often showed where staff had contacted people's family to ensure their needs were being met.

The provider had a complaints policy. People and their relatives told us they knew who to contact if they had concerns around the service. Since our last inspection the people's relatives felt confident their concerns would be responded to by the new management team. For example, one relative told us, "I had an issue. I have a chat with (registered manager) and it was sorted. I know I can raise a concern and it will be dealt with."

The registered manager kept a record of complaints and complements they had received. They recorded how many complaints were received on a monthly basis. Where complaints had been received these were recorded alongside a clear response to the concerned party. Where lessons could be learnt, these were discussed with staff.

## Is the service well-led?

### Our findings

At our last inspection in July 2016, we found the provider did not have effective systems to monitor the quality of the service and the views of people, their relatives and staff were not always acted upon. These concerns were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach had been continued from our inspection in March 2016, where we had issued the provider with a warning notice. Due to this continued breach and the failure of the service to meet the regulations; a positive condition (a positive condition is an instruction we place on the provider's registration which they must follow) was imposed on the provider in relation to the management of the service and people's care records. We found since our last inspection improvements had been made. The service was starting to become well led.

Following our last inspection, the director of operations had implemented a "Quality Toolbox" system for all services operated by the provider designed to monitor the quality of service and drive improvement. This system had been implemented from October and November 2016. This system contained a range of audits, such as medicine audits and care plan audits. Medicine audits were carried out on a monthly and weekly basis and had had a positive impact on the administration of people's prescribed medicines, as errors in the administration and recording of people's medicines had reduced. However other audits had only recently been implemented and therefore we were unable to assess how effective they would be at continuously drive improvements within the service. For example care plan audits, infection control systems and resident of the day checks. Therefore whilst audits were being implemented, we could not always evidence the improvements they had had on the service, or the consistency of how these systems drive improvements within the service.

Since our last inspection a new manager had been recruited and had been registered with the Care Quality Commission as a registered manager. People and their relatives spoke positively about the registered manager and the positive impact they had had on the service. Comments included: "Since (registered manager) has been in post the service has got better and better and better" and "I think things have improved a great deal. The manager is very good and communication has vastly improved."

Care staff spoke positively about the changes in management and told us that the registered manager was approachable and their door was always open. One member of staff said "I think there has been a big improvement and the communication between staff and management is much better". Another staff member told us "The manager leads the team and doesn't take any nonsense".

People and their relative's views were now being sought and were starting to be acted upon. The last survey of the views and experiences of people and their relative's was carried out in October 2016. The results showed whilst there were positive responses, there were also areas where people and their relatives felt the service required improvement, which included areas such as being involved in discussions about their or their relatives care, the availability of fresh fruit, promoting independence and activities. The provider had responded to all feedback and documented the action they had or were taking in response to these concerns. This included informing people and their relatives that fresh fruit was available on request from

the kitchen, and plans that were in place to involve people in their relatives care and improve the provision of activities. The outcome of this questionnaire was available for people and their relatives to view in the homes reception area. While surveys of people's views had been carried out it was not always easy to identify if the actions had been consistently implemented. For example, improvements around activity provision and the wellbeing of people was still being considered and ongoing.

The home carried out monthly family meetings. These meetings were used to discuss changes in the home as well as seek people's views. Information such as inspections and the resident of the day scheme the provider had implemented were discussed. Relative survey results were also discussed. Relatives spoke positively about the information they received and their ability to feedback on the service. One relative told us, "I am kept up to date and we now have regular residents meetings where we can give our feedback. They send out surveys too and are always looking at ways to improve".

The provider and registered manager had also carried out a survey of staff views and asked visitors to complete a short questionnaire when they visited the home. Information on these surveys was available for people and their relatives to view. Staff spoke positively about the questionnaire and the ability to air their views. One staff member said, "It's very open and transparent. We are now one team, where before it felt like it was us and them."

Representatives of the provider carried out monthly checks of the service, and the registered manager supplied them with monthly report of events within the home. Where shortfalls were identified these were added to the service's continuous improvement plan. The director of operations and registered manager updated the continuous improvement plan on a regular basis and shared the document with healthcare professionals and commissioners. This plan contained action plans which covered all areas of the home, including staff training and meal time observations. Where actions had been completed these had been signed as completed. All actions were passed to a member of staff who was responsible for the completion of that task.

Since the registered manager had been in post they and the nursing staff had been complimented and won a local reward regarding information they had provided regarding tissue viability. This is something the registered manager and clinical lead were proud of. They had also sought the guidance and advice of other professionals. For example, they explained to us how they alongside the maintenance worker had asked the local health and safety team to visit the premises and provide them with clear guidance regarding the home. The registered manager stated that when they came to the home there were limited records over the quality of the service or how the building was maintained and this was something they had addressed.

The registered manager had support from the operations director and director of operations. As well as this the director of operations was encouraging peer support from managers of other homes owned by the provider. On one day of our inspection the manager of another home came to Chapel House to provide support. Managers were supported to peer review other homes which would inform part of the providers quality assurance systems. The registered manager told us that they felt supported working at Chapel House. The director of operations also told us that there were monthly managers meetings where managers could discuss current events and areas for improvement. The director of operations and registered manager spoke positively about this process.

Peoples care records were not always stored securely. For example, on one day of the inspection people's ongoing care documents were being held in communal areas of in corridors. We discussed this with the registered manager and director of operations, who ensured us action was being taken. When we returned to the service for a second day, people's ongoing records were stored in their rooms in file holders.

Additionally on the first day of our inspection, we were able to access the home's care record computer system, as a door to the nurse's station had been stopped from closing and the computer had not been locked. We discussed this concern with the director of operations as people's personal information could be accessed or viewed inappropriately. The director of operations told us they were taking immediate action, which included ensuring doors were locked and that all staff and visiting healthcare professionals will be reminded to lock computers.

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
Treatment of disease, disorder or injury	People did not receive activities, stimulation or engagement which met their needs or preferences. Staff did not always engage with people and ensure care was person centred. Regulation 9 (1) (a) (b) (c).