Stonehaven (Healthcare) Ltd

Chollacott House Nursing Home

Inspection report

61 Whitchurch Road
Tavistock
Devon
PL19 9BD

Tel: 01822612811
Website: www.stone-haven.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The unannounced inspection took place on 7, 13 and 18 April 2016. Our previous inspection in January 2015, found that the service had breaches in the regulations inspected of the Health and Social Care Act (2008). These related to monitoring the quality of service, medicines management, staffing, assessment, planning and delivery of care and accuracy of records. The provider sent us an action plan setting out how they had already met the breaches.

Chollacott House is a family run business. The nursing home provides nursing and personal care to a maximum of 42 people, many of whom have complex needs. Some live within the Drake Unit which accommodates people with neurological conditions. There were 35 older people resident at the beginning of the inspection.

The service is required to have a registered manager. 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. Chollacott House had a registered manager.

The service monitoring had not always led to a safe, quality service for people because the monitoring had not always identified where improvement was needed.

Medicine management had improved but some risks still remained, such as not always recording whether any allergies existed. Further improvements were made during the inspection visits.

The home was superficially clean but some equipment in regular use was stained and dirty and increased risk from cross contamination.

Personal care needs were not always met, such as two people's finger nails being broken and dirty, which upset a person and a family member.

Some people's clothing left them at risk, such as a broken shoe strap which could lead to a fall.

There was a programme of upgrading the premises but some environmental risks had not been identified and were not being dealt with within a quicker timescale. Some were addressed during the visit.

Some people's legal rights were not upheld in line with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, such as not assessing a person's capacity to make an important decision. People who were able to provide informed consent had that consent sought before they received care or treatment.

Staff expressed concern and kindness for people but this was not always translated to a kind and caring

service where people could feel valued, such as finding out why a person was distressed.

Staffing arrangements took into account people's assessed needs and were under regular review.

People's dietary needs were understood and monitored. Most comments about the food were positive and there was a varied menu which was adapted to meet individual preferences.

People were protected through safe recruitment practice, staff training and supervision. Staff spoke very highly of the training they received.

People's views were sought through regular resident and family meetings, care plan reviews and a yearly survey of opinion. Their views had been taken into account by the provider.

People had a variety of activities available to them including the use of the minibus for outings, arts and crafts, exercise and a newly developed garden area. One staff member said of the activities worker, "She makes every day special for people".

People's needs were assessed and planned with theirs, or their family's, involvement. Care plans related to either the personal care or health care needs of the person so the plan was clear for care and nursing staff to follow.

People felt able to take issues to the registered manager who investigated and followed through on any complaints. People and staff spoke highly of the registered and deputy managers.

We found four breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). You can see what action we asked the provider to take at the back 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?

Requires Improvement

The service was not always safe.

There were improvements in medicine management but areas of risk remained.

Some equipment was unclean and increased the risk from cross contamination.

Some areas of the premises required immediate attention for people's safety but a programme of upgrading was in place.

Staff were rostered taking into account people's assessed needs and staffing was under regular review.

Individual risks to people were managed for their safety and there was regular overview to look for trends of concern.

People were protected through the safe recruitment of new staff.

People were protected from abuse and harm.

Is the service effective?

Requires Improvement

The service was not always effective.

Some people's legal rights were upheld. In some cases restrictions had not been authorised and decisions around people's capacity to make informed choices was not adequately assessed.

In some cases people's personal care needs were not met to a level acceptable to them.

Staff received a variety of training, which they enjoyed and which gave them the information they needed to do their work.

A nutritious diet, with individual choices respected, was available for people. Dietary intake was monitored and where concerns were identified they were followed up.

People's health care needs were met through the knowledge of

staff and engagement with external health care professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

A lack of attention from staff adversely affected some people's quality of life but people had formed relationships of importance with staff members who expressed kindness and concern for them.

Confidentiality regarding personal information was not always upheld and so people's privacy was not always maintained.

People's views were sought in different ways so they could influence the service they received.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed, planned with them and regularly reviewed. Staff had good knowledge of people as individuals.

There was a broad range of activities available for people, who were benefitting from different opportunities.

The registered manager responded to complaints, which were investigated and actions taken as necessary.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service was monitored in many different ways and risks to individuals had been reduced, but there was not always a safe, quality service for people.

Ways to improve the service were under regular review.

The management team were respected and there was strong leadership.

Chollacott House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 7, 13 and 18 April 2016. The first two visits were unannounced. The third visit was announced so we could be sure the registered manager would be available.

Two adult social care inspectors and a pharmacist inspector completed the inspection.

Before our inspection, we reviewed information we held about the home, which included incident notifications they had sent us. A notification is information about important events which the service is required to tell us about by law.

A number of people living at the service were unable to communicate their experience of living at the home in detail as they were living with dementia. 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 comment directly on their experience.

We spoke with 11 people using the service who were able to comment directly on their experience, four people's family and two people's friend/visitors. The medicine administration for 10 people was observed. We looked at four records of care, including risk assessments and 25 medicine records. We spoke with 12 staff members and the registered manager. We looked at records connected with how the home was run, including training and recruitment records, records of staff meetings and quality monitoring surveys. We received information from two community health and social care professionals and a community pharmacist.

Requires Improvement

Is the service safe?

Our findings

Our previous inspection of January 2015 found that there were not appropriate arrangements in place for safe medicine management and administration of medicines. This inspection found medicine management was still not safe but there had been some improvements. There were also concerns regarding the staffing arrangemets, but those concerns had been addressed through employing additional nursing staff. This had improved the health and nursing care people received.

The home used printed medicine administration records (MARS) supplied by the pharmacy to record medicines administration. The MARs were accurate and it was possible to check that people were receiving their medicines as prescribed. However, If people refused to take their medicines then the date, time and reason for refusal were not always recorded, meaning it was not always possible to identify a reason for ongoing refusal, for example swallowing difficulties.

Information about people's allergies to medicines was found on an Allergy Information Form in the front of the MAR folder. This information was not always completed on the actual MAR or in care plans. For example, one person's care plan said they were allergic to a pain killer used to treat moderate to severe pain. This allergy was recorded on the Allergy Information Form but not on their MAR. This could potentially lead to them being given a medicine to which they are allergic.

Homely remedies (medicines which can be administered without being prescribed) were used in accordance with a signed and dated Homely Remedies List. Medicines administered without being prescribed were recorded in a homely remedies book but not on peoples MARs. This means that medicines that interact might be given or too many doses of similar medicines as all the information was not on the MAR. A bottle of cough mixture was marked as expired on 11 April 2016 was still in use in the Homely Remedies cupboard, however the last dose had been administered on 7 March 2016, whilst in date.

Creams and other topical applications were applied by care staff. Topical Medicine Application Records were completed to show which cream needed to be applied and these were signed by care workers after application. However, the record did not always show the full directions for use of the cream, the time and site of application or the amount needed. This means that creams and other external medicines could be applied at the wrong amount and on the wrong area of the body. There were also some creams which appeared to be prescribed and shown on the MAR for which there was no Topical Medicine Application Record.

Separate recording charts were used for the application of medicated patches which showed the date of application and removal of patches as well as the site of application, which should be rotated on the body. The site of application was not always completed and if it was, records showed that the position of the patch was not rotated according to best practice. If the patch was applied to the same area of the body, then more of the medicine might be absorbed which could lead to overdose.

People were not asked if they needed medicines that were prescribed to be taken when required. One

person was observed to be given a pain-killer which was prescribed to be taken when required without being asked if he needed it. When asked, the person told us "I take my tablets when I get given them" and that "I still get pain in my knees". Some people had a 'When Required Protocol' with their MAR that gave more information about their particular medicines, but these were not seen with every person prescribed a when required medicine.

There was evidence in some care plans of people's requirement to self-manage their medicines, but this did not include all medicines which people were administering themselves. For example, one person had a self-medication assessment in their care plan for administration of their eye drops, but not for the inhaler which was also kept in their room. This meant it was not assessed if they were able to apply the inhaler and receive the medicine effectively.

A person living in the setting was seen to be using oxygen. The room was not clearly marked with the appropriate hazard warning stickers and oxygen cylinders stored in the medicines room were not secured, meaning they could fall and cause injury.

Medicines were stored securely, with access controlled appropriately. The temperature of rooms where medicines are stored was recorded every day. One medicines room was within the required range but the room on The Drake Unit was recorded as being above 25°C on 12 days in April (inspected on the 13th). This means that medicines may deteriorate more quickly than expected and may not be effective.

People, who may have lacked the mental capacity to make a decision about taking their medicines, were not properly assessed against the Mental Capacity Act 2005. Care plans included instructions from the GP to give medicines covertly to two people, but there was no evidence that best interest meetings, with a representative for those person, were held. Medicines that could have been given covertly had not been assessed by a pharmacist as being suitable to mix with food. This means that medicines given this way might not be effective.

Information about covert administration of medicines was not reviewed in people's care plans. One person, who had a risk assessment for covert administration in their care plan dated 8 August 2015, was not having their medicines administered covertly when we inspected. This decision was not documented in the care plan and could lead to confusion if the person refused to take their medicines.

Reference sources were available for medicines, but they were not always up to date, for example one medicines room contained a reference material dated September 2007. Care plans did not contain medicine related, patient centred information to ensure that people received care that was appropriate to their needs. However, we were informed that staff used on line reference material.

The community pharmacy ran a medicines audit at the setting on 24 August 2015. A record from the audit could not be found during our inspection although the pharmacy confirmed the report had been sent to Chollacott House in August 2015. Following our request a second copy of the audit report was sent to the registered manager who said the findings were fed back to the clinical lead nurse. Some issues identified during that audit had been acted on, for example, recording the date that a pain relieving patch was applied. However, some issues remained, and posed a risk to people. For example, a person's allergy status not being recorded and insufficient information on when as required medicines were to be administered.

People's safety was not always fully promoted. One person was wearing a shoe with a broken strap, which could pose a trip hazard. We saw another person sitting on the side of their bed. In front of them were a pair of shoes which had shoe tacks sticking through at the heel. This would have caused harm if worn. We

immediately informed the registered manager about our concern and they dealt with this by getting insoles for the shoes.

In one room the window pane was cracked and there was, what appeared to be, an old telephone connection box under the sink. Wires were sticking out of it. The registered manager said this room was one already included in a programme of upgrade. In the lounge there was loose wiring coming from a wall and an extension lead which could cause a trip hazard. Where we fed back any issue which might relate to people's safety this was responded to immediately, for example removing a sharp edge from a radiator cover. However, this had not been identified by the service.

Some areas of the home were not clean. For example, several call bell consoles were stained and sticky to the touch and would pose a risk of cross contamination because they were handled by staff and people using the service. One person's bin lid had ingrained staining and some skirting boards were grubby. There were bits of paper under one bed, a tooth mug did not seem to have been cleaned for days and the foot rests on some moving and handling equipment contained debris.

We fed back after the first visit the areas which we found were unclean and by the second visit the areas we had highlighted had been cleaned. However, we then found other areas in the same condition.

We had received feedback from people who had visited the service, where a lack of cleanliness was mentioned. One described the home as "dirty" and a second said they had just wiped a windowsill with a wet wipe and the floor needed hoovering.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

The nurse on duty was seen to administer medicines in a caring manner and spent time with people to ensure that medicines were taken. Adjustments were made to the timing of medicines rounds to ensure that everyone received their regular medicines when they needed them and if the person was not ready for their medicines, then staff would call back at a later time.

There was a process for ordering medicines that meant the service had enough medicines in stock. Medicines received into the home were checked and signed in by nurses. Nurses knew how to make sure that accurate information was received about medicines when new people arrive at the setting either via transfer from hospital or from home. There was evidence of reviews of people's medicines by the GP or other healthcare professional. These were documented in people's care plans and actions such as discontinuing medicines were acted upon.

Some medicines had been handwritten on the MAR charts, for example antibiotics received during the month. Handwritten additions to MAR charts were signed by the person making the addition and usually signed as checked by a second person, which is good practice to ensure accurate records.

People taking high risk medicines had additional written information from the GP with their MARs, to ensure that the correct dose was given in response to regular blood tests and specific MARs were used to record the administration of different strengths of these high risk medicines.

Medicines that require additional controls because of their potential for abuse were stored safely. Stock checks were completed and there were no discrepancies between the drug register and actual drugs in stock. These drugs were administered and witnessed by two staff members who both completed the entry

into the drug register and MAR. Medicines requiring refrigeration were stored appropriately and the temperatures checked daily to ensure the fridges maintained the correct conditions.

The medicines policy had recently been reviewed and reflected processes in the service. There was evidence that the service received and shared safety alerts about medicines and equipment. The service received newsletters and information from the local Clinical Commissioning Group (CCG) regarding medicines use in care homes. There was a programme of nurse training available and all nurses were encouraged to attend.

One person's feedback described the cleanliness as good. There were no mal-odours and superficially the premises looked clean. Staff had personal protective clothing available for use and were seen using it. There was hand washing facilities for staff and hand gel to increase protection from cross contamination. An outbreak of diarrhoea and vomiting in May 2015 had been responded to correctly to reduce the impact and protect people.

Some areas of the premises and furnishings needed upgrading; for example, in one person's room an easy chair had a bed pillow in place of a seat cushion. However, we were shown two bathrooms which had recently been upgraded and informed about, for example, the refurbishment of the dining area and new lounge and conservatory carpets. New equipment had been purchased to aid people's safety, such as specialist beds, moving and handling equipment, and a specialist chair for recording people's weight.

There was a programme of building risk management. This included the level of risk, any servicing agreements, who was affected, who was responsible and frequency of assessment or action. For example, there was a six month contract agreement for gas safety.

One person's representative said the only problem with the home was the conservatory temperature, which they found too warm. The provider had fitted sun screening heat retaining shields to reduce the problem.

Our previous inspection found staffing deployment did not ensure people would receive the level of care they required. This mostly related to a lack of qualified nurses for the size of the home and the complexity of people's needs. The provider then increased the number of nursing staff. The registered manager said the service now always aimed to have two nurses on duty in day time, one for the Drake Unit, where nursing hours were increased to six daily. The staffing rota showed this was happening. Nursing and care staff were supported by domestic, laundry and catering staff.

Care staff described there "usually" being enough staff to meet people's individual needs. Staff said about staffing arrangements, "Yes, there are enough staff and back up (staff) for activities, kitchen, and always staff to call on in an emergency" and "Sometimes there are enough staff and sometimes no". One said some staff not turning up left staffing shortfalls. The service used agency staff to cover expected shortfalls and we were told the deputy manager was usually available to meet any last minute staffing shortfalls.

One person said it would be good if staff had time to talk to people. People were supported to get up in the morning and receive their breakfast and medicines within a reasonable time during our visits.

The registered manager said that the deputy manager, when providing care, assessed people's needs against their care plans and informed her where staffing may need a review. In addition, nursing staff fed back any staffing issues. Recruitment of nurses was ongoing, with the newest recruit starting during the inspection.

Staff were recruited following checks on their suitability to work with vulnerable people. For example, each

person had completed an application form and been interviewed. References were sought and a DBS check was completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. There was a system in place to check that nursing staff were current on the nursing register.

People were protected from abuse. Staff had received "compulsory" training in how to protect people from abuse and were able to describe how they would alert any concerns which might indicate abuse. They said they were aware of a safeguarding policy and where it was kept. Staff said they would take concerns to the nursing staff, senior care staff, deputy or registered manager. If necessary they said they would contact the provider, local authority or CQC. One person using the service allegedly hurt another during the inspection and this was reported to the local authority safeguarding adult's team, as it should to be in line with local safeguarding protocols. Health care professionals and commissioners were involved in discussions regarding the support that person needed for their own welfare and that of others.

Each person had risks relating to their health assessed as part of their care planning. These were regularly reviewed and action taken where risk could be mitigated. For example, if a person had unexpectedly lost weight.

Our inspection of January 2015 found that accidents in the home were not adequately monitored, with a view to reducing risk to people. This inspection found accident records were completed and better organised. Arrangements for increasing people's safety were improved; the clinical lead nurse produced a monthly audit, including falls, accidents, incidents, pressure area care with actions taken. This was then reported to the registered manager and fed back to the nurses, for praise or where any action may be needed.

Requires Improvement

Is the service effective?

Our findings

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 at Chollacott House were completing forms with regard to people's capacity but they did not relate to specific decisions, were not time specific, were not always under regular review and not all decisions required were included.

One person said they wanted to leave the home. The registered manager directed us to her assessment of the person's capacity. However, this was a generic assessment and did deal with the specific issue of a return to the person's home. A community professional confirmed the person's presentation of capacity fluctuated and so any assessment of the person's capacity to make the decision to leave the home also needed to be at a time when they were most likely to be able to make the decision. Although external professionals were involved there was no record of a best interest meeting and the person's care plan had no reference to specific events around the person moving from the home.

One person did not have access to their belongings, which were locked away from them. There was no reference to the locks in the person's care file. The registered manager said there had not been any mental capacity assessment toward the decision nor a best interest meeting regarding the decision. The person's family said they had been fully informed about the restriction and were in agreement with it and there was reference to a conversation about this.

People can authorise others to act on their behalf in case they later lack capacity to make specific decisions. This is called lasting Power of Attorney (LPA) and is specific to either care and welfare or financial matters. Where this happens the staff need to be aware of the details of the authorisation so they, or external professionals treating the person, can act as the person had authorised, in line with their wishes. Staff were unable to say who had LPA and who did not and so were not aware of the details of people's authorisations and how they might be required to respond.

One person had recommendations made by a dentist, including regular tooth cleaning. The person's toothbrush had not been used that morning. We were told the person's family member had made a health care decision on their family member's behalf about dental treatment. However, there was no record of that decision in the care file. Nor was there any mental capacity assessment or best interest paperwork to that effect.

One person's assessment included that family had LPA but did not state whether this was for care and welfare or with regard to their finances.

Where one person wanted to go home the registered manager was working with the person's family members. However, the registered manager said she had asked to see the LPA but had not yet seen it. This

meant staff could not be sure there was authorisation for family members to make decisions on the person's behalf.

We saw that consent to care forms had been signed by people's relatives. However, there was no indication that a mental capacity assessment had been undertaken to establish that the people were unable to consent for themselves.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

Where people had capacity to provide informed consent their consent was sought and recorded. This included, for example, for the staff to administer medicines on their behalf, the use of bedsides and money management.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). A document used at Chollacott House included whether a DoLS application was needed.

One person was being unlawfully deprived of access to their belongings because this had not been considered as deprivation.

We saw that both urgent and standard DoLS applications had been made for one person and standard DoLS applications for other people. However, staff members were unsure who was subject to DoLS, referring to the registered manager. Staff providing care and treatment needed to know to whom any DoLS applied so any specific safeguards could be met.

The registered manager confirmed she had received training in the MCA in September 2013. Her response to our reference to the Cheshire West judgement, 19 March 2014, which was a legal judgement which widened and clarified the definition of deprivation of liberty, indicated she was not adequately aware of the judgement. The judgement was widened to include any person who would not be allowed to leave the premises and any person who was under constant supervision without their informed consent. The registered manager was booked to attend an MCA refresher course in May 2016.

People and their families said they thought staff were competent and knew how to provide the care they needed. Comments included, "You really can't fault the care", "No complaints as far as care is concerned. Staff are excellent" and "The staff are dedicated." One person said staff had not always dealt with her teeth as she wished in the beginning, but they did now. One person's family said they occasionally had to nudge staff, for example, when the person's hair was getting long, but the person was content and staff looked after them well.

Our previous inspection of January 2015 found that proper steps had not been taken to meet people's needs and ensure their safety and welfare. This related, in particular, to nurses meeting health care needs. At this inspection we found those concerns had been addressed.

People had access to external health care professionals. For example, people had necessary blood checks, a specialist hospice nurse had visited one person, community psychiatric advice was sought and speech and language therapy assessment was seen to be arranged. A health care professional said, "(The staff) are willing to listen to my suggestions".

People's families said that foot, hearing and eye care was arranged for people and a care plan assessment showed that one person was to be registered for domiciliary dentistry and eye care on their admission.

Chollacott House was using the Care Certificate standards for new staff induction. They had mapped the courses across to Social Care on-line training to be sure each areas of training would be included. Staff were able to shadow experienced staff when new to the home, until their competence was checked and they were confident in the role. One person's family said that new staff seemed to fit in well at the home.

Staff said they liked the style of training provided. Their comments included, "Excellent, I am really pleased with it. The (provider) is very supportive of any training I want to do". Their training included aspects of health and safety, such as moving people safely, fire training and first aid awareness. Also, conditions associated with people's needs, such as dementia care and stoma care. The organisation aimed to ensure best practice was used. For example, a virtual dementia tour was arranged to help staff understand what living with dementia might be like. Some staff had completed training in end of life care, through a local hospice. Staff were encouraged to take qualifications in care and helped to progress their career if this was important to them.

The organisation recognised the importance of staff receiving regular support to carry out their roles safely. Staff received on-going supervision in order for them to feel supported in their roles and to identify any future professional development opportunities.

Staff said they felt well supported. Records confirmed that each staff member had a senior responsible for their supervision, for example, the clinical lead supervised the nursing staff and the deputy manager supervised the senior care staff. One domestic said they found the supervisions useful, adding "You can get things off your chest".

Where concerns about the attitudes, values and behaviour of individual staff were identified these were followed up with additional supervision, training and monitoring.

Staff said the arrangements for communicating information worked well. This included regular handovers at shift changes, when staff were informed which people they were to care for. Senior care workers were responsible for checking work and directing care workers with any additional things that needed doing.

One person said about their lunch, "Not too bad. There is always a choice. Today the choice was salad and I love salad". Another said, "It was edible but I can't say I enjoyed it". One person's family described the food as "good". The cook said there were two daily choices of main meal unless the meal was a roast. They described one person who would make clear what they wanted to eat, and this was provided, adding, "Whatever they want, they have". They said the registered manager would ask staff to go and fetch any item the home did not have at the time. The cook said she attended residents' meetings where people discussed the menu. The menu was varied and included curry and fish dishes.

Special diets were listed on a board in the kitchen so staff were clear what was needed. These included, for example, some people needing a 'soft' diet, one who liked a small portion, and some who required supplements to boost their weight. One person was identified at risk from choking and professional advice was being sought from a speech and language therapist.

People's weight was monitored and the results reviewed by the clinical lead nurse and then discussed with the registered manager. One person's weight had been identified as a concern. The person's GP had been informed. However, we saw that person's porridge, uneaten, was removed by one staff member, but a staff

member later recorded that all the breakfast was eaten, when it was not. We informed the registered manager of this discrepancy.

Requires Improvement

Is the service caring?

Our findings

A lack of attention to detail adversely affected some people's quality of life but people had formed relationships of importance with staff members. One person described the staff as "bright and bubbly".

Some staff focused on the tasks in hand rather than the individual. For example, one person had a third full drink put in front of them without the staff member asking if the others were still needed. They didn't check with the person to see if the other drinks needed removing.

Staff did not always provide a level of care which promoted dignity and demonstrated that the person really mattered. A visitor said the person they visited would occasionally ask them for help to clean their teeth, as they needed cleaning. We also found personal care needs were not always being met. For example, two people, whose personal care needs were to be met by staff, had long, unclean finger nails, some broken. The person said they did not like having such long nails.

One person was admitted to receive end of life care. When we met them they had a poster of a celebrity directly in front of them, which they wished to look at, but it was falling off the wall having been put up in a manner which was not going to stay up. They asked us to reposition the poster, which we did, but it was unlikely to last. We fed this back to the registered manager but do not know in what way it was corrected because the person was not there for our following visit.

More than half of the clocks/watches we saw had an incorrect time, and so provided incorrect information for people, some who were living with dementia.. A calendar showed an incorrect date and a visitor said there was no water in the person's flowers and their bin was overflowing. We did not check this at the time.

One person was struggling to use a beaker, unable to find the spout. They were unable to convey that they needed assistance because the call bell console was just out of reach and we confirmed it was not working. The person was trying to call for attention but we twice saw a member of staff walk past the room without taking notice. On the third occasion the member of staff went into the room, removed an uneaten bowl of porridge but did not ask them if they were alright. They did not appear to notice the person was distressed; therefore they did not act on this. When we later returned to the room the person seemed more distressed and we found a member of staff, who attended them immediately.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

When staff were aware of people's needs they met them quickly and with empathy, for example one person said they were too hungry to wait for lunch and so theirs was brought prior to the lunch time. Staff expressed concern for people's wellbeing and there were examples where they showed their concern in a caring and meaningful way. Some staff engagement with people showed kindness, for example, one person was smiling as the care working assisted them.

Personal care was provided in private but people's personal information did not always remain confidential because personal files were kept in the lounge/dining area in the Drake Unit and could be viewed by any person using the area. We also found a letter which had mistakenly been misfiled. This was a potential break of the person's confidentiality in addition to that information being missing from the person's file.

Staff expressed concern for people and were able to describe people's individual needs and preferences and how they liked their care to be provided. Concern was shown for people's welfare. For example, a nurse meeting October 2015 included how to ensure people remained warm enough through the winter months. One relative told us that her family member had "a few incidents where she was confused and became unsettled, but the staff responded well". She was "very happy with the care". A message for staff said, "I cannot praise the staff enough…nothing is too much trouble. They looked after her with care and kindness". Another person's visitor described a nurse massaging cream into the person's hands and applying "a bit of makeup", which made the person feel good.

People's views were sought through review of their care plan, which was monthly, and regular residents' meetings, where people had the opportunity to comment on the service and make suggestions. There was also a yearly survey of opinion about the service where people's views were reported.

The service provided end of life care and two staff had recently completed specialist training in the subject through a local hospice. Some people's families had sent cards thanking staff. Comments included, "Thank you for looking after mum so well", "Thank you for all the kindness and care shown to mum" and "Thank you for the kind and caring way you looked after her during the whole time she lived with you." One person's family praised the staff because they had taken the person to a family funeral. Staff were said to have dealt with "the situation" very well.

Good

Is the service responsive?

Our findings

Our inspection of January 2015 found that a lack of depth of information during assessment, care planning and health monitoring had led to people's needs not always being responded to, particularly nursing issues. The service said they were meeting this shortfall by ensuring that the clinical lead nurse would always complete nursing needs assessments and reports. This is what we found.

Following assessment each person had a plan written with theirs, and family involvement, if appropriate. Care plans are a tool used to inform and direct staff about people's health and social care needs. All the care plans we looked at contained essential information, including a narrative giving a sketch of the person's life. This would enable care staff to have knowledge of the person's background and form a basis for conversation and planned activities.

Care plans were divided into a section for care workers and a section, called a 'Health Action Plan' for nurses. One care plan for care workers described in detail one person's communication difficulties and how staff could interpret what they were trying to communicate. Health Action Plans included detailed information relating to health care needs, such as how much fluid a person required to maintain their health and specifics about medical equipment.

People confirmed they were involved in reviews of their care plans. Staff confirmed they used the care plans, adding that they had to sign to confirm they had seen each change. Care plans had been regularly reviewed and where necessary updated to reflect the person's current needs.

There was a very enthusiastic activities worker who, according to a staff member, "Makes every day special for people". The home had a minibus available for some periods. People had described some outings as "brilliant". Staff said the Christmas tree was dressed with all hand crafted decorations from people using the service and they brought fashion magazines from which people made 'mood boards'.

The activities worker described taking four "gents" out to the pub and baking cocoanut ice with people. One person was taken back to their home community where they met with people they had known since they were young. This meant a lot to them.

The activities worker visited each person each week and gave a list of what was happening for that week. For example, painting people's nails and outings in the minibus. Gardening was soon to restart and there was a pleasant, enclosed garden available to people. 'Wake up and wiggle' (exercise) sessions took place and reminiscence was being developed. People's families were bringing in items toward this. A weekly magazine called The Weekly Sparkle provided people with historic news items for discussion and some word games.

Activities was a regular topic at the resident and relative meetings. At the meeting of 31 March 2016 people were asked for ideas for outings. Those already planned included Buckland Abbey and Dartmoor Zoo. The garden improvements were also discussed.

Where a complaint was made it was acted on. A complaints procedure was displayed within the home and the registered manager said it was also taken to residents' meetings. It provided information on the procedure for handling complaints. The registered manager said that where ever possible an issue was dealt with immediately it was raised. One person had raised some points of concern about their family member's care. They told us, "They have acted on every point I had raised" and spoke very highly of the staff and the registered manager. The registered manager was able to describe how people's gestures and body language was used to identify if something was wrong should they be unable to communicate verbally.

One person had made a complaint because a person using the service had entered their room without being invited. We saw that the sign for privacy they had requested was in place.

Requires Improvement

Is the service well-led?

Our findings

Our inspection of January 2015, found that there was a lack of effective systems to assess and monitor the quality of the service provided and identify, assess and manage risks relating to the health, welfare and safety of people using the service. This led to monthly auditing, for example, of all accidents and falls and any weight loss, which had been effective in helping to protect people from harm.

This inspection found a structured system for monitoring the quality of the service provided. Audits were weekly, monthly, quarterly and annually. However, they could still not be deemed effective because there were aspects of the service that were still not safe. For example, the service undertook a monthly audit of their medicines that looked at what medicines were in stock for each person but this had not identified the concerns we found. Audits did not include whether people's rights were being upheld under the Mental Capacity Act 2005. Unsafe situations, including a lack of cleanliness, and the state of people's footwear, had not always been dealt with in a timely way, which increased risk.

There was a monthly provider visit on 13 April 2016, the report from which showed that maintenance issues identified were followed up and the décor was upgraded. Cleaning and hygiene were assessed. The report said, 'General walk around presented well'. However, another provider visit the same day, specifically to look at cleanliness described some as 'very poor'. Cleanliness had been raised in staff meetings previous to this visit, one record from a February 2016 team meeting including that all equipment should be wiped down by care workers. This was mentioned again in a March 2016 team meeting. We still found some equipment to be unclean.

The issues identified by the CQC inspection, with the exception of the lack of cleanliness, had not been identified through the provider monitoring visits.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

A yearly 'How are We doing' survey, March 2016, as part of the service quality monitoring recorded that 13 people, or their family members, were completely satisfied with the service and two were 'somewhat' satisfied. 15 of the 35 surveys provided had been returned. Regular residents' meetings also provided a forum for people's feedback and suggestions.

Staff said about the leadership at Chollacott House, "Extremely well led" and "Usually" well led." They described a manager who was always there to listen "day or night". One staff member said how this helped them to relax and enjoy their work more. One staff member said "We are truly lucky to have (the deputy and registered managers) here. Good management". Another staff member described how each member of staff was considered to be equal, regardless of their role. One said the deputy manager seemed to be "everywhere at the same time" and another said how well the home was organised: "You know all the time what you must do". Staff also mentioned the support which was available from the organisation's central office.

The provider listened to requests for improvement. For example, it was agreed that a large shed would be erected for improved storage space and a larger manager's office.

A nurse said that they have input if they feel something is not right, or something is not done and they can always go to the registered manager "because she is good and will listen".

Staff looked for ways to improve the service. The CQC inspection of January 2015 found accurate records and appropriate information and documents were not always available and complete. Following the inspection the clinical nurse sought the expertise from a community nurse to look at how nurse records were used at Chollacott House. Most records, such as monitoring charts, had been completed in full. Their completion was part of the regular service monitoring.

Plans were underway to replace the hand written recording system with a computerised system, as a way of improving record keeping. The registered manager recognised the amount of work, and potential risks related to such an important change.

Following our feedback steps were immediately taken to improve. For example, a memo was sent to the supplying pharmacy asking for people's allergies to be included on the medicine record, and a sharp edge on a radiator cover was made safe.

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 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 Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Where a service user might not have capacity to make informed consent, specific, and time related assessment was not always made in line with the Mental Capacity Act 2005. Regulation 11 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for people because there was not proper and safe management of medicines, surfaces which staff and service users touched were not kept in a clean and hygienic state so as to reduce risk from cross contamination and risks were not always identified and mitigated where this was possible. Regulation 12 (2) (a) (b (g) (h)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider did not have effective systems in place so that all that was reasonably practicable to do to identify and mitigate risk was done. Regulation 17 (1) (2) (a) (b)

The enforcement action we took:

We issued a Warning Notice which must be complied with by 30 September 2016