Panaceon Healthcare Ltd

Chapel View Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 31 August 2016 and was unannounced.

Chapel View is registered to provide nursing and personal care for up to 39 older people. The home is purpose built and has accommodation and communal areas across two floors. At the time of our inspection there were 35 people using the service. The home was not providing support to anyone with nursing care needs.

The service is required to have a registered manager, and at the time of our inspection there was no registered manager in place. There was a manager in post and their application to the Care Quality Commission (CQC) to become the registered manager was being processed. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There had been a planned increase in the number of new people admitted to the home in the month prior to our inspection. Some concerns were raised about the availability of sufficient staffing to meet people's needs safely. The registered provider had taken action to review and increase staffing levels to reflect the increased numbers of people supported, but rotas for the previous month and feedback we received showed that there were occasions where sufficient staffing had not been promptly deployed to cover gaps in the rota. We have made a recommendation about this in our report.

Cleaning schedules were in place, but we noted a number of areas of the home that required greater attention with cleaning and maintenance, in order to ensure standards of hygiene were consistently maintained. We have made a recommendation about this in our report.

Staff had completed Mental Capacity Act (MCA) training and where people had a condition on their Deprivation of Liberty Safeguards (DoLS) authorisation, we saw that the registered provider was ensuring this condition was met. However, care files lacked information about people's capacity to consent to their care and demonstrated a lack of staff understanding about who could sign to give consent to decisions if the person lacked capacity. The registered manager was taking action to address this. We have made a recommendation about this in our report.

The registered provider had policies and procedures in place to guide staff in safeguarding vulnerable adults from abuse and staff had received safeguarding training.

The provider had a safe system for the recruitment of staff and was taking appropriate steps to ensure the suitability of workers. We found that people's needs were assessed and risk assessments were in place to reduce risks and prevent avoidable harm. Regular maintenance and equipment checks were also

completed.

Medication was appropriately stored, administered and recorded on medication administration records. Staff responsible for administration of medication had received training and the registered provider completed medication audits. This showed that there were systems in place to ensure people received their medication safely.

Most people told us they were satisfied with the quality and variety of food available and the home was taking action to increase the variety of food available. People were supported to ensure they got sufficient to eat and drink and their weight was monitored. However, record keeping in relation to food and fluid intake was poor and could not always clearly evidence the action staff had taken in relation to dehydration risk and weight loss. We have made a recommendation about this in our report.

Staff completed an induction and a range of training to help them carry out their roles. Training considered essential by the provider was refreshed annually.

People were supported to maintain good health and access healthcare services. We saw evidence in care files of contact with healthcare services, such as GPs, speech and language therapists, and dieticians. Visiting healthcare professionals we spoke with told us that staff acted on the advice they gave in relation to people's healthcare needs.

People who used the service, and visitors, told us that staff were caring and we observed positive and friendly interactions between staff and people who used the service. People's independence was promoted and their privacy was respected.

Care plans were reviewed monthly and contained information about people's needs and preferences. Staff were also able to demonstrate a good understanding of people's needs.

There was a complaints, suggestions and compliments procedure in place and records showed that complaints had been appropriately investigated and responded to.

There was a quality assurance system in place, which included a range of audits conducted by the registered manager and deputy manager, as well as an external audit of the home. The quality audits had not, however, been fully effective in addressing some of the concerns we identified in our inspection.

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.

The registered provider had taken action to review and increase staffing levels, but there were still occasions where they had been unable to promptly deploy sufficient staffing to cover gaps in the rota, in order to ensure people's needs were consistently met.

Improvements were required to hygiene practices and maintenance in some areas of the home.

The registered provider used a robust recruitment process, to ensure that people were supported by staff who were considered suitable to work with vulnerable people.

There were systems in place to ensure that people received their medication safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received a comprehensive induction and regular refresher training.

Improvements were required in staff's understanding and practice in relation to the Mental Capacity Act and consent to care.

People were supported with their nutritional needs but record keeping in relation to food and fluid intake, and response to weight loss, was not robust.

People had access to healthcare services, where this was required, in order to maintain good health.

Is the service caring?

Good

The service was caring.

People and visitors told us staff were caring and we observed positive and friendly interactions between staff and people who used the service.

We saw that people's independence was promoted and people's privacy was respected.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care plans were in place to enable staff to provide personalised care. Staff demonstrated an understanding of people's individual needs and preferences.

There were systems in place to respond to complaints and concerns, and to listen to the views of people who used the service.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Feedback about the management of the service was generally positive and staff were supported in their roles.

There were quality assurance systems in place but these had not been fully effective in addressing the concerns we identified in our inspection.

Chapel View Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 31 August 2016 and was unannounced.

The inspection team consisted of two adult social care inspectors.

Before our visit, we looked at information we held about the service, which included notifications sent to us. Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also received feedback from Barnsley Council's joint commissioning team.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of this inspection we spoke with five people who used the service, four visitors to people who used the service and two visiting healthcare professionals. We also spoke with the manager, five care staff and a cook. We looked at three people's care records, four people's medication records, four staff recruitment files, staff training and supervision records and a selection of records used to monitor the quality and safety of the service.

Requires Improvement

Is the service safe?

Our findings

We asked people who used the service if they felt safe living at Chapel View Care Home. Everyone we spoke with said they did, with comments including, "I feel perfectly safe; probably because you are never far away from someone," "I feel safe" and "I feel safe, because there's always people about."

We spoke with the registered manager, staff and people who used the service about the availability of sufficient staffing to meet people's needs safely. We received mixed feedback from people who used the service. One person told us, "I think they are short of staff, because you are waiting a long time." They did however tell us that the time it took staff to respond to their call bell was, "Not bad; they do come. It varies; they can't do everything at once." Another person told us, "I don't think there are enough staff." Others did not raise concern with us about staffing levels.

One visitor we spoke with told us, "They get busy; sometimes you have to wait an hour or more [for support with getting changed] because they are short staffed…I get the feeling they are under pressure, but they do their best." However, other visitors did not raise any concerns about staffing levels and one told us, "There seems to be enough staff."

When we spoke with the manager about staffing levels they told us they told us there had been a planned increase in new admissions to the home recently, and that they had increased staffing by an extra carer in the mornings and an additional member of staff on a night to reflect this; hence the new staffing levels were five carers in the day and three at night. There had been 12 new admissions to the home in the month prior to our inspection, and over half of these were people having a respite break at the home, for about seven days on average. The manager also told us they had covered shifts at night occasionally if they had been unable to get agency staff to cover.

The majority of staff we spoke with raised concern about staffing levels. One told us, "The only problem [here] is there is not enough staff on." We asked about the impact of this on people who used the service and they said, "It takes longer to get people up. I don't think they [people who used the service] get as much attention as they would if there were more of us… they have to wait longer." Another member of staff told us, "[Staffing levels] can be unsafe on a morning [referring to the period at the end of the night shift, before day staff arrive in the morning]; a number of people require two carers. One carer does singles and two carers do double ups. But when all three of you are off the floor what is happening to people already up?" A third staff member told us, "I think staffing levels is a big problem, not having enough people to help you. It's the first time I've worked with five on shift. There are sometimes three or four." They told us that the impact on people was that they did not get bathed as often.

We looked at bathing and shower records for four people to determine if staffing levels had impacted on people's personal care needs being met, as suggested by two staff members. Records showed that whilst people had been washed, three of the four people had not had a bath or shower every week in the six weeks prior to our inspection. For one of these three people, there was no record of a bath or shower being offered for just over three weeks, and for another there was no record of a bath or shower for 19 days. The fourth

person received support from their family with showering, as this was their preference. We also observed during our inspection that some people presented as though they required more support with their personal care. The registered provider told us this was because staff had failed to correctly document when people had refused a bath and were taking action to address this.

On the day of our inspection there was one senior carer and four carers on shift, reducing by one carer after 1:30pm. There was also a manager, deputy manager, a cook, a maintenance person, an administrator and two domestic staff. The atmosphere in the home was calm and staff did not appear hurried on the day of our inspection. On two occasions, however, we had to draw staff attention to the fact that seats in the communal lounge had become soiled or were wet with urine, to prevent other people sitting on them, because staff had not been available to notice and address this. We looked at rotas for the last four weeks and these showed there were generally four or five care staff during the day and three care staff on a night. Chapel View has a full time deputy manager in addition to this. In the two weeks before our inspection there had been a number of days where a fifth carer was on shift until 1:30pm. We noted, however, one occasion over the previous month where the staffing level had dropped to three care staff between 1:30pm and 5:30pm. We were advised the manager covered care duties to ensure continuing quality of care. We also found that, due to unforeseen sickness, there were four occasions where the staffing levels at night time (between 7:30pm and 7:30am) had dropped to two care staff and the home could not arrange for alternative cover from its bank staff or from their list of agency staff providers. On three of these four occasions the number of people who used the service varied between 26 and 29 people; on the fourth occasion there was over 30 people supported by two care staff. This was significant because of the size and layout of the home, which was spread over floors, and because some people required two staff to support them with certain personal care or repositioning tasks. The impact on clients was minimized by a manager arranging to stay late (until 10:00pm) and the other manager to attend early (from 5:00am).

This showed us that although the registered provider had taken action to review and increase staffing levels to reflect the needs of the increasing number of people who used the service, there were occasions where sufficient staffing had not been promptly deployed to cover gaps in the rota, and staff told us this had impacted on the delivery of care.

We recommend the registered provider continues to monitor and review staffing levels on a regular basis, in order to consistently ensure the deployment of sufficient staff to meet people's needs.

The registered provider had an infection control and prevention policy and cleaning schedules were in place to ensure the home was kept clean and hygienic. We also noted that infection control had been discussed in a recent team meeting. Despite this, some areas of the home needed greater attention to cleanliness and some areas required refurbishment in order to ensure hygiene standards could be appropriately maintained. For instance, many hand rails were worn which made them difficult to keep hygienically clean. A communal bathroom had a tile missing behind the sink and the underside of the toilet and commode were stained and required cleaning. Mops were stored incorrectly and the lock on the door to the cleaning cupboard was faulty, making it difficult for all staff to access if required. We noted a number of people's rooms needed vacuuming, including the carpet in one person's bedroom that was listed as having been cleaned that day.

We noted a number of cushions in the communal lounge which were covered in a bin liner, with another cushion placed on top. We were told this was to make them moisture resistant, but this was not a hygienic or cosmetically pleasant solution to the issue. Some areas of the home were mildly malodourous. When we spoke with the manager about these issues, they told us they completed a daily walk around of the home to identify any cleaning issues, and usually ensured these were addressed straightaway. The manager took

some immediate action on the day of our inspection, to amend the cleaning schedules in order to make the specific tasks required in each area of the home clearer. They also told us that they had recently sourced a new cleaning products supplier, and were awaiting new products that week, as they had not been satisfied with the current cleaning products in use.

We recommend the provider takes action to address these issues and ensure all areas of the home are regularly cleaned and appropriately maintained.

The registered provider had policies and procedures in place to guide staff in safeguarding vulnerable adults from abuse. All staff received safeguarding training as part of their induction, then regular refresher training thereafter, including discussion in team meetings. Staff demonstrated some understanding of how to safeguard people who used the service; they were able to explain some types of abuse that could occur and told us they would report any concerns to the manager. We noted though that some staff were less knowledgeable about all the types of abuse that could potentially occur, so the manager agreed that they would re-iterate this in team meetings and assess people's knowledge in individual staff discussions.

The registered provider held a copy of the local authority safeguarding procedure on file, as well as a record of all safeguarding referrals made and investigations completed. The registered provider also had a whistleblowing policy, which enabled staff to report issues in confidence and without recrimination. This showed that the registered provider had a system in place to manage safeguarding concerns and protect people from avoidable harm and abuse.

People had appropriate risk assessments in relation to their individual needs. These included assessments in relation to continence needs, falls, moving and handling, skin integrity and bed rails where required. The Malnutrition Universal Screening Tool (MUST) was also used to assess people's risk in relation to malnutrition. Risk assessments were reviewed monthly. Personal emergency evacuation plans (PEEPs) were in place, or in the process of being updated, for people who would require assistance leaving the premises in the event of an emergency. These detailed the support people would require in the event of an evacuation. The registered provider also had a range of service risk assessments in relation to generic risks, such as legionella, moving and handling, the laundry and use of certain kitchen equipment. These were reviewed annually and were up to date at the time of our inspection.

We saw that records of any accidents or incidents were completed and these were reviewed by the manager to ensure appropriate action had been taken in response to any incidents. The manager recorded information about accidents and incidents on a log so that data could be analysed monthly to identity patterns and action required.

We looked at documents relating to the maintenance of the environment and servicing of equipment used in the home. These records showed us that equipment was regularly checked and serviced at appropriate intervals. This included servicing of the passenger lift and hoisting equipment, fire extinguishers, emergency lighting and electrical wiring. Checks also included legionella sampling, portable appliance tests on portable electrical equipment, window restrictor checks, water temperature checks and call bells system checks. These environmental checks helped to ensure the safety of people who used the service.

The registered provider had a safe system for recruiting staff. We looked at recruitment records for four staff. We saw that appropriate checks were completed before staff started work. These checks included seeking appropriate references, identification checks and registration checks for nursing staff. The registered provider also completed Disclosure and Barring Service (DBS) checks. DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help

employers make safe recruitment decisions and prevent unsuitable people from working with vulnerable groups.

We looked at systems in place to ensure people received their medication safely. The registered provider had a medication policy and staff responsible for administering medicine had received training in medication management and were assessed for their medication competency.

People's care files contained a care plan with details of any support required with medication. We looked at a selection of Medication Administration Records (MARs). We found that these were appropriately completed, to show that people had received their medication as prescribed. We checked the stock balance for a number of medications and the stock held tallied with the stock level recorded on the MARs. We saw from the most recent medication audit, and staff meeting minutes, that the registered provider was taking action to put new topical cream administration records in place for people who required prescribed creams.

We saw that fridge temperature checks were recorded daily to ensure that medicines stored in the fridge were safe to use. Some prescription drugs are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled drugs and there are strict legal controls to govern how they are prescribed, stored and administered. We found that controlled drugs were stored correctly and that controlled drugs records were accurately completed. The stock balance for controlled drugs was correct. We found one controlled drug in the cupboard with an expired 'use by' date. The manager confirmed this medication had been for someone who no longer used the service, and that collection and disposal of the medication had been arranged with the pharmacy service. After the inspection the manager confirmed it had been returned.

We also observed medication being administered and spoke with staff about various aspects of medication management, including medication administration and storage. Staff demonstrated a good level of understanding.

This showed us that there were systems in place to ensure people received their medication safely.

Requires Improvement

Is the service effective?

Our findings

We asked people who used the service if staff had the right skills and experience to meet their needs. People told us, "I haven't asked them to do many things, but they haven't failed…They are willing and helpful", "They know their job. If I ask for anything they get it for me" and "I can't find any faults; everything is done and if I ask them for anything it's done." One visitor, however, suggested there was some inconsistency; "There are some lovely girls here, but some of them don't know their job."

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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 process for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the registered provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection, two people were subject to a DoLS authorisation and the registered provider had submitted a further five applications. We saw that appropriate support was provided to ensure conditions on DoLS authorisations were met.

Care files lacked information about people's capacity to consent to their care. In one file we viewed the person had not signed consent to their care file, and when we discussed this with the manager they told us this was because the person lacked capacity to consent to their care. There was no record of the registered provider having completed an assessment of this. We also noted that in a care plan audit completed on this file, an action had been recorded for staff to request that this person's family sign the consent to care form, due to the person lacking capacity. However, this instruction was incorrect, because the person's family did not have Lasting Power of Attorney for health and welfare, and as such, did not have the authority to provide consent on the person's behalf. In another care file we viewed the person's relative had been asked to sign consent to the care plan, but again they did not have the appropriate authority to do this.

Staff had completed on-line MCA training and were able to demonstrate a basic understanding of the importance of gaining consent before providing care to someone, but the documentation we viewed demonstrated that improvement was required in staff knowledge and application of the MCA. When we spoke with the manager about this they told us that they had already identified this as an area for improvement, following similar feedback from the local authority, and the deputy manager had an individual MCA training session booked the month following our inspection with a member of staff from the local authority. Following this, they would be reviewing mental capacity documentation and consent to care documentation in care files, and cascading the training information to all staff.

We recommend the registered provider ensures the planned training is completed, seeks guidance on best practice from a reputable source and takes prompt action to ensure the principles of the MCA are consistently followed.

We asked for people's views about the variety and quality of the food available at the home and feedback was generally positive. Whilst the menus rotated each week, similar options appeared every week, but on different days, so the menu lacked variety. People who used the service had not chosen what had gone on the current menu, and this was confirmed by staff and people. The manager told us this issue had already been recognised and they were in the process of developing a new seasonal menu with input from people who used the service. We saw that the menu had been discussed at a recent resident's meeting.

We observed a mealtime at the home and saw that people ate in the dining room or in their own bedroom. There was a quiet atmosphere in the dining room and tables were laid with cloths, glasses and condiments. People were offered a choice of what to eat and drink. A pictorial menu was available showing the main meal options that day. The food served looked hot and people appeared to enjoy it. Staff provided assistance to cut up food where required. We noted that food was served at different times, so people who were sat on the same table ate separately; in some cases more than 10 minutes apart. Some people had also been sat at the table for over half an hour before any food arrived because of the length of time taken for staff to support people to come to the dining room and ascertain everybody's choices.

When we spoke with the chef, they were knowledgeable about people's special dietary requirements and had an information board with people's individual needs in the kitchen. Care files contained information about people's nutritional needs, including information about the type of diet required and food preferences. We found some files would benefit from more information about people's food and drink preferences. For example, one person's nutritional care plan contained limited information about their food preferences, yet in the 'life history' section of their care file there was a lot more information available which could have been utilised to help inform their nutritional care plan.

Staff told us people's food intake was monitored if they were at risk of weight loss. They also explained that if someone had lost weight, a referral to the GP or dietician would be made and senior carers made sure they prompted people to drink additional fluids on a 30-minute basis if someone was at risk of dehydration. People were weighed monthly and the manager completed a report each month to monitor people who had lost weight. The monthly weight chart showed that most people's weight was relatively stable, and that where there had been weight loss for some individuals, the manager was aware of the reasons for this, such as a period of ill health.

We found however, that the nutrition section of one file we viewed lacked any information about what responsive action had been taken when the person had lost a significant amount of weight in a six week period. The nutritional risk assessment had also been incorrectly calculated and had not been updated since the 13.kg weight loss had been identified three weeks before our inspection. There was however, an entry elsewhere in the file which showed that the GP had been consulted and visited the person due to their weight loss, and they had made a referral to the memory team and dietician. This showed that appropriate responsive action had been taken, but this had not been clearly recorded in the nutrition and weight section of the care file.

The fluid intake records for two out of three people we viewed showed that there were some days where they had received significantly below the recommended daily intake. The fluid taken was not totalled at the end of each day and it was not clear what action had been taken to encourage extra fluids. There was also no detail in the care plan for one of these people about their dehydration risk. The manager told us that

audits of the daily notes, including audits food and fluid intake charts, were not completed. They agreed to implement this immediately, so that any issues with people not receiving sufficient fluids were identified promptly.

A visiting healthcare professional told us staff sought appropriate advice from them where required; "They have contacted me in the past to make referrals about weight loss" and another healthcare professional told us their team had not had any concerns about people's nutrition and hydration needs not being met at Chapel View.

From all the information available, including weight records and feedback from staff and healthcare professionals, we concluded that people were supported with their nutrition and hydration needs, but record keeping to evidence this was poor and action was required to improve the way that staff recorded their response to weight loss and their monitoring of food and fluid intake for people at risk of malnutrition and dehydration.

We recommend the registered provider seeks guidance on best practice and ensures staff accurately record action taken in relation to weight loss or dehydration risk, in order to monitor whether strategies employed are effective and meeting people's needs.

People were supported to access healthcare services. We saw evidence in care files that people had received support from healthcare professionals where required, such as GPs, speech and language therapists and dieticians. People told us, "Staff have organised for them [GPs] to come here or I go there" and "If I am poorly they [staff] come up and see me. If you need a doctor you just let them know" and "The district nurse visits me three times a day." One visiting healthcare professional told us, "They [staff] seek advice if they are ever concerned about people or need advice. Generally they act on the advice I give." Another visiting healthcare professional we spoke with confirmed that staff followed the advice and instructions they gave them.

Staff completed an induction and training on a range of topics, such as; first aid, food safety, infection prevention and control and medication. They also completed a variety of on-line training, including moving and handling, health and safety, fire safety, equality and diversity, dementia, safeguarding vulnerable adults and COSHH (Control of Substances Hazardous to Health). Before working independently, new staff shadowed more experienced workers for at least three shifts, depending on their learning needs and experience.

Training considered essential by the registered provider was refreshed annually and training records were held on file. The registered manager told us that 13 staff had just been enrolled on an NVQ [now known as a diploma in Health and Social Care]; level two, three or four, depending on their role. The deputy manager was also completing the level five leadership qualification.

We saw evidence of staff supervision and team meetings; both covering a range of appropriate topics. Records showed that staff usually had a formal supervision meeting every three months. An 'Informal Discussion Document' was used to record any issues that had arisen in relation to staff's performance, with any reminders or instructions to staff.

This showed us that people received care from staff that received the training and support they needed to carry out their roles, and additional training about the MCA was being organised.

Good

Is the service caring?

Our findings

We asked people who used the service if staff were caring. Feedback we received was positive, with comments including, "They [staff] are quite nice people", "They treat me with respect, they are very decent" and "I've not had any sort of problems with staff since I've been here." Visitors to the service told us, "There are some lovely people. They certainly seem willing", "The staff are lovely. They talk to people and are generally nice staff" and "I think it's a good home, good staff; caring…I've got no complaints about staff. They are very social and they have got time for you." A visiting healthcare professional told us, "The staff seem to be caring. I have no concerns about that."

Staff we spoke with demonstrated a caring approach towards the people they supported. They told us, "All the staff are nice" and "I think they [the staff] are all quite caring." Comments from staff did, however, indicate that they did not get time to sit and chat to people as much as they would like to. One member of staff told us, "I like to have conversations with people, but you find you don't have time to do that."

We observed staff supporting people throughout our inspection and interactions were positive and friendly. We also observed staff offering choices and responding to requests from people. Staff were able to describe how they offered people choice, and gave specific examples of how they showed and explained options to people. A visitor told us, "They have asked what [Name] likes; they have gone through a long list of likes and dislikes."

Care files gave instructions to staff on how to promote people's independence wherever possible. For example, one person's care file stated, "Requires one member of staff to assist with all personal care needs, however independence is to be promoted at all times where possible. [Name] is able to wash [their] own hands and face, and prompting from staff is required for [Name] to remove and clean dentures." We saw staff encouraging people to do things for themselves where possible, such as at mealtimes.

Discussion with staff indicated that there were no people who used the service that had any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010: age, disability, gender, marital status, race, religion and sexual orientation. Most people who used the service could potentially be at risk of discrimination due to age or disability, but we saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this. A church service was held at the service once a month, to support people to continue to practice their religious beliefs if they wished. The registered provider had a fair access, diversity and inclusion policy and procedure. They also had a 'choice of carer gender' policy and the registered manager told us how they organised staffing to ensure they were able to meet one person's preference for a male carer to support with their personal care.

Staff we spoke with understood the importance of respecting people's privacy and dignity and were able to explain how they put this in to practice. They gave examples such as ensuring people's door and curtains were closed when providing them with support. We saw throughout our inspection that doors were closed when people were receiving support in their own rooms and staff always knocked on people's doors before

entering their rooms. Nobody who used the service raised concern with us about staff not respecting their privacy. However, we observed that some people's personal care needs had not been attended to in a timely manner, which did not preserve their dignity.

Nobody who used the service had an advocate at the time of our inspection. An advocate is someone who can provide support to help people express their views and wishes, secure their rights, represent their interests and provide access to information to inform people's choices. Many people had support from family or friends.

Visitors we spoke with told us they were able to visit any time; one told us, "They make me feel welcome." They also told us that staff kept them informed of any concerns or appointments. They told us, "When [Name] went to hospital they rang me up. When they've got appointments they ring me up; I've no problems" and "They always ring if there's a problem."

Good

Is the service responsive?

Our findings

People told us they were content living at the home, and the support provided met their needs. Comments included, "I can't find any faults…If I ask them for anything it is done" and "Up to now it's very good. I find it okay."

The registered provider had produced a care plan for each person who used the service, to ensure staff had relevant information and people received care and support that met their needs and preferences.

The registered provider completed an assessment of people's needs, before they moved into the home, to ensure the service could meet their needs. This assessment formed the basis of the care plan, which was further developed when people moved to Chapel View. Files included care plans in relation to skin integrity, moving and handling, nutrition, continence, medication, activities and any other specific needs or short term care plans required. There was information about people's needs, the support required from staff and some detail about people's individual preferences. For example, we saw examples of instructions to staff about preferences in relation to how people's personal care needs should be met. This meant that staff had the information they needed to provide personalised care to people.

When we spoke with staff they were knowledgeable about people's needs. Staff told us they got to know people and their life history, by talking to the person and their family. Staff also told us they were encouraged to read people's care plans, although explained that it could be difficult to find time to do this because they were often busy on shift.

We could see from the records held that care plans were generally reviewed monthly and updated where required.

Entries were made in each person's daily reporting notes, to monitor any issues or changes. This included observations about whether the person had slept well, participated in any activities and whether there had been any changes to their usual routine, mood or health. Bed rail checks and positional change records were maintained for those who required them.

The registered provider organised activities each day. On the day of our inspection, there was a coffee morning taking place, which was attended by some people who lived at a neighbouring care home (owned by the same registered provider). We were told the coffee morning took place every Wednesday. One person who used the service led a sing-along, which was joined in enthusiastically by most people attending the coffee morning. After the sing-along there was a bingo session. There was another communal lounge where others sat quietly and less activity was taking place.

People told us, "There are games; we have a games room with dominoes or cards if you want to play cards" and "We play cards, dominoes, do painting and there's a church service once a month." A relative told us, "[Name] does activities either here or across the road each day of the week. They do bingo, keep fit and have had animals in. [Name] makes an effort to do something different. There was a gala day last Saturday, with a

buffet." However, one person who used the service told us, "They don't have many activities at all; not ones that affect me. I'm sure if I wanted to do something and put it to them it would get done though." A visiting healthcare professional told us, "We don't notice much going on." We observed that whilst there were activities taking place in the communal areas, there was less activity and opportunity for interaction for those who were cared for in their own bedrooms. We were told that these people were offered the opportunity to be taken to the lounge, or to have additional services in their own room, such as hairdressing and manicures, but we did not observe these activities on the day of our inspection.

There was a complaints procedure in place and a system to record and respond to complaints. The complaints procedure was available to people who used the service and we saw from minutes of a 'resident's meeting' in August 2016 that people were reminded who they could raise concerns with. Records showed that four complaints had been received in the last year and the registered provider had investigated and responded to these. There were also three compliments recorded in the last year. A visitor told us, "If you have a problem you can speak to staff in the office and they sort it."

We saw from recent minutes of resident's meetings that people had opportunity to share their views about their care and issues at the home, such as activities and the new autumn menu that was being planned. Three resident's meetings and one relative's meeting had been held in 2016.

This showed us that people were encouraged to share their views and there was a system in place to respond to complaints.

Requires Improvement

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of their registration for Chapel View. The home had been without a registered manager since February 2016 but there was a manager in post and their application to the Care Quality Commission (CQC) to become the registered manager was being processed. There was also a full time deputy manager for the service, who typically did administrative duties two days a week.

We spoke with people about the management of the service. One person who used the service told us they thought the service was well-led was because, "Things happen before you ask for them. You don't have to ask for things, they are there. Things get done and sorted out." Another told us, "The person who runs this is very nice." Visitors to the service told us, "[Manager] was fantastic [when my relative had to go for a medical procedure]" and "If anything is wrong [Manager] is approachable and sorts it out." Another told us, "Nothing's too much trouble for them [Manager and Deputy Manager]." A visiting healthcare professional told us, "[Deputy Manager] is particularly good. We've noticed a difference since they've been there."

Comments from staff included, "[Deputy Manager] is brilliant and gets things done" and "The deputy manager and manager are approachable." They told us there had been a number of management changes over the last three and a half years, so it was nice to now have a stable management team. Another staff member told us, "You can approach them and they listen, although it doesn't always mean you get what you want." Comments from staff also suggested that staff sometimes felt under pressure to take additional shifts, due to staff shortages.

The registered manager told us they kept up to date with best practice and legislation by looking at the Care Quality Commission's (CQC) website, attending local authority provider forums and regular management meetings and calls with the company directors. Key information about best practice and any changes in legislation was shared with staff in team meetings. The manager also told us they were planning to introduce 'champions' in certain areas of practice, including sight and hearing, dementia and infection control, and had sourced additional training for champions to complete. Champions would then promote and encourage best practice amongst other members of the team on an on-going basis.

We looked at minutes of staff meetings in February, April and July 2016. Topics discussed included reminders about practice issues, staff team work and attitude, new documentation and forthcoming training. We saw staff received regular supervision and appraisal. This showed us that staff were kept informed and given opportunities to reflect and improve on practice.

The service had systems in place to audit the quality of the care they provided to people. The registered provider completed a range of audits. These included monthly audits in relation to medication, care plans, infection control, dining experience and the environment. The manager was required to send monthly reports to the director, and a conference call was held each month to discuss and review the findings. The manager was also required to send a range of additional information to the director each week, including information about any events, complaints and compliments, medication issues, accidents, agency usage,

expenditure, safeguarding issues and training. We were told a director usually visited the home once a week and provided support to the manager.

The manager told us that the registered provider had also commissioned an external audit of the home, and had just received a preliminary report from this. They told us an action plan was being formulated to address issues identified. This demonstrated a commitment to monitoring and improving the quality and effectiveness of the service provided.

Each monthly audit resulted in the manager producing a list of any required actions. However, we identified that these action plans did not record when each action had been completed. We spoke with the manager who told us this had already been discussed with the director and that the format of the audits would be changing to include this.

We saw some examples where actions from audits had been completed, such as the implementation of new topical cream administration records. However, we found that the quality auditing system had not been fully effective in addressing the other issues we identified during our inspection such as concerns about staffing levels, infection control, MCA documentation and record keeping in relation to bathing and nutrition and hydration. For example, we looked at the care plan audit for a person whose file we identified had lacked information about staff's response to weight loss. The audit for this care plan had not identified any concerns with the nutritional care plan or recognised that it had not been updated since the person was last weighed. Fluid intake records were not audited. The care plan audits had been ineffective in recognising the lack of information in care files about people's mental capacity and evidence of their consent to care. Incorrect advice had also been given in two care plan audits we viewed about who should sign to consent to the person's care.

We spoke with the manager about this. They told us it had been recently agreed that they would be working with the manager of the registered provider's other home to audit each other's practice and care files, in order to create a greater level of scrutiny and objectivity in the auditing system.

Whilst there were plans in place to address a number of the identified issues, such as training planned to increase MCA knowledge and the new system to increase the independence and objectivity in the auditing system, at the time of our inspection some of these plans were still being implemented so we were not yet able to view evidence of their impact on practice. Therefore we found that although systems were in place to monitor and review the delivery of care and the quality of service that people received improvements were required to ensure these were effective.

Policies and procedures were in place, and based on up to date legislation and guidance. We asked for a variety of records and documents during our inspection. Overall we found these were easily accessible and stored securely.