Acer Healthcare Operations Limited

Chestnut Court Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on the 25 and 26 September 2018 and was unannounced. This was the first inspection of this service since it was registered with its current provider.

Chestnut Court Care Home is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. This service is a purpose-built care home spread over three floors, each floor operates as an independent unit. The service provides support with nursing and personal care to older people, many of whom are living with dementia. The service is registered to provide support to a maximum of 62 people and 59 people were using it at the time of our inspection.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were enough staff working at the service to meet people's needs and robust staff recruitment procedures were in place. Appropriate safeguarding procedures were in place and safeguarding allegations were managed appropriately. Risk assessments provided information about how to support people in a safe manner. Procedures were in place to reduce the risk of the spread of infection. Medicines were managed in a safe manner. Steps had been taken to ensure the physical environment was safe. Lessons were learnt when accidents and incidents occurred.

People's needs were assessed before they started using the service to determine if those needs could be met. Staff received on-going training to support them in their role and undertook induction training on commencing work at the service. People were able to make choices for themselves and the service operated within the principles of the Mental Capacity Act 2005. People told us they enjoyed the food and that they had enough to eat. People were supported to access relevant health care professionals.

People told us they were treated with respect and that staff were caring. Staff had a good understanding of how to promote people's privacy, independence and dignity. Confidentiality was respected and records were held securely.

Care plans were in place which set out how to meet people's individual needs. Care plans were subject to regular review. People were supported to engage in various activities. The service had a complaints procedure in place and people knew how to make a complaint. End of life care was managed in an appropriate way.

Staff and people spoke positively about the senior staff at the service. Quality assurance and monitoring systems were in place which included seeking the views of people who used the service. The service worked

with other agencies to develop good practice.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Appropriate safeguarding procedures were in place and staff understood their responsibility for reporting any safeguarding allegations.

Risk assessments were in place which provided information about how to support people in a safe manner.

Checks were carried out to help ensure the premises were safe.

The service had enough staff to support people in a safe manner and robust staff recruitment procedures were in place.

Medicines and infection control practices were managed in a safe way.

Is the service effective?

Good

The service was effective. People's needs were assessed before they started using the service. People and their relatives were involved in this process.

Staff undertook regular training to support them in their role. Staff had regular one to one supervision meetings.

The service operated within the principles of the Mental Capacity Act 2005 and people were able to make choices about their care.

People were able to choose what they ate and drank and they told us they had enough to eat.

People were supported to access relevant health care professionals as required.

Is the service caring?

Good

The service was caring. People told us they were treated with respect by staff and that staff were friendly and caring.

Staff had a good understanding of how to promote people's dignity, privacy and independence. People's right to confidentiality was protected.

Is the service responsive?

Good

The service was responsive. Care plans were in place which set out how to meet people's assessed needs in a personalised manner. These were subject to regular review.

People were supported to take part in various activities, both in the service and in the community.

People knew how to make a complaint and complaints had been dealt with in line with established procedures.

The service supported people with end of life care in a dignified and caring manner.

Is the service well-led?

Good

The service was well-led. The service had a registered manager in place. People and staff told us they found senior staff to be supportive and helpful.

Systems were in place for monitoring the quality of care and support at the service. Some of these included seeking the views of people using the service.

Chestnut Court Care Home

Detailed findings

Background to this inspection

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

This inspection took place on the 25 and 26 September 2018 and was unannounced. The inspection team consisted of two inspectors, a specialist advisor with a specialism in nursing care and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we already held about this service. This included details of its registration and any notifications of significant incidents the provider had sent us. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We contacted the local authority with responsibility for commissioning care from the service to seek their views.

During the inspection we spoke with five people using the service and four relatives. We interviewed 14 staff; the registered manager, head chef, housekeeper, activities coordinator, three nurses, two senior care assistants and five care assistants. We spoke with two health professionals who were visiting the service at the time of our inspection. We reviewed six sets of staff recruitment and supervision records. Medicines were examined on all three floors at the service. We checked health and safety records and the systems in place for monitoring the quality of care and support provided. We read minutes of various meetings and checked some of the policies and procedures.

Good

Is the service safe?

Our findings

People told us they felt safe at the service. One person said, "Yes I do feel safe. I have my own room and there are locks on all the doors. The security is safe. I have a gate on my room door and this prevents other residents who wander from the other end of the corridor getting in my room. I have a pendant which I use to call to staff if needed. I have had no accidents or falls here." Another person told us, "Yes I do feel safe because I have everybody looking after me instead of being home in my own. The staff do help me if I am in trouble."

Systems were in place to help protect people from the risk of abuse. A safeguarding adult's policy was in place which made clear they had a responsibility to report any safeguarding allegations to the local authority and the Care Quality Commission. Staff understood issues relating to safeguarding and were aware of the different types of abuse. They told us if they suspected a person was being abused they would report it to a senior member of staff. One member of staff said, "I would report it straight away to whoever was in charge on the day."

Risk assessments were in place for people. These set out the risks faced and included information about how to mitigate those risks. They covered risks associated with skin integrity, moving and handing, catheter care, choking, medicines and behaviour. Records showed that risk assessments were followed. For example, where they stated people needed to be re-positioned due to the risk of developing pressure ulcers, re-positioning charts were in place. We checked these and found them to be completed in line with the instructions in the risk assessments.

Staff understood the individual risks people faced and they were able to tell us how the provided care and support in a safe way. At times, some people exhibited behaviours that challenged the service. Staff told us they did not use physical restraint when working with people. They said they sought to help people to calm down by giving them space and time, diverting their attention and giving them re-assurance.

The service maintained regular health and safety checks. These included checks and risk assessments on equipment to ensure that all were working correctly. We saw that where fault was found actions were taken. These checks included gas safety and appliances, water safety, room temperature, hoists, wheelchairs and mattresses as well as on other equipment. The service maintained fire safety at the home. There was an up to date fire policy and procedure and regular fire assessments and drills were completed. The service had emergency evacuation plans in place for people using the service.

Most people told us there were enough staff to support them. One person said, "If I press my call bell staff come as quickly as they can." Another person said, "Yes I do think there is enough staff." Staff told us they had enough time to carry out their duties, one member of staff said, "We have five or six in the mornings and four or five in the evenings (staff), it's enough."

One staff member said more staff would be helpful, but added that the staffing levels were sufficient to provide support that was safe. The registered manager told us it was 'very infrequent' for a shift to go

uncovered if a staff member was off sick, and nursing staff were authorised to book a replacement staff if required. We looked at the staffing rotas for a three-week period. These showed there was one day when for a short period one of the floors was one staff member short. Otherwise, there was a full complement of staff at all times. We observed staff responded to people in a prompt manner during our inspection. When we heard an alarm call, this too was responded to promptly.

The service had safe recruitment practices in place. We looked at six staff recruitment files and saw the service completed various pre-employment checks on staff including criminal record checks, employment references, proof of identification and a record of previous employment. This meant the service sought to employ staff who were suitable to work in the care sector.

Medicines were managed in a safe way. People told us they were supported with their medicines. One person said, "They bring me my medicine and I know what it is for." Only trained staff administered medicines, which were stored securely in locked medicine cabinets within designated treatment rooms. Appropriate storage facilities were in place for controlled drugs. Medicine administration records were in place which included details of the name, strength, dose and time of each medicine and these were singed by staff after each administration. This meant there was a clear audit trail of medicines given. Guidelines were in place to advise staff on when to give people PRN (as required medicines). Audits and checks were in place to make sure medicines were managed appropriately.

Steps had been taken to reduce the spread of infection. Cleaning schedules were in place which set out what had to be cleaned and the frequency of doing so. Staff signed these schedules each time a cleaning task was carried out. The head of the cleaning staff told us they checked both the cleaning schedules to make sure they were completed and also routinely checked the areas themselves to make sure they had been cleaned to a satisfactory standard. We observed the premises to be mostly clean on the days of our inspection. However, we found that it was dirty under one of the kitchen sinks. The head chef told us this area was very difficult to access as the sink was attached to the wall. On the second day of our inspection we noted the area was considerably cleaner then on the first day, but was still not totally clean. Staff told us they were expected to wear protective clothing including gloves and aprons when providing support with personal care and we observed staff to be wearing these items.

Lessons were learnt if accidents or incidents occurred. The service maintained a digital system that recorded all accidents and incidents and they were reviewed by the registered manager and other senior managers in the organisation. This information was analysed and shared with the local authority and local clinical commissioning group as appropriate. Actions were taken to reduce the risk of similar incidents occurring again.

The registered manager and the staff team held reflective practice in clinical meetings to learn from incidents. An example of a lesson learned we noted was a change being made to admission paperwork around the frequency of skin checks following a discussion around privacy and dignity versus accountability. The discussion had centred on a person using the service having unseen pressure sores due to the service protecting their right to privacy.

Good

Is the service effective?

Our findings

The registered manager told us they carried out an assessment of a person's needs prior to them moving into the service. This was to determine not only what the needs were but if the service could meet them. The assessment process involved speaking with professionals already involved in the person's care, their family and the person themselves. Records confirmed assessments were carried out which looked at needs in relation to the person's medical history, sexuality, social and spiritual needs, communication, mental health, sight, speech and hearing. Relatives were encouraged to visit the service before making a decision about whether it was suitable for the person. The registered manager said, "I always encourage the resident and family member to come and visit the home before moving in."

New staff undertook an induction training programme on commencing work at the service. A staff member said of their induction, "When I came here I thought I was going back to school [because of the high standard of the induction]. After the E-learning somebody that has worked here for a longer period then you have, works with on the floor for four or five days."

The registered manager told us the service was in the process of training some care staff to be 'senior practitioners'. Five staff were about to complete this training and a further five had been identified to start it in the near future. This training was to provide the staff with relevant skills and knowledge to take on more responsibility, for example, the administration of medicines.

Staff told us and records confirmed they had regular training. One staff member said, "I've had lots of training. Moving and handling, fire safety, medicines, first aid, safeguarding." Records confirmed training took place and was up to date. We noted that some staff were undertaking first aid training on the premises on the day of our inspection.

Records showed staff had one to one supervision meetings with a senior member of staff. The registered manager told us they had recently updated and improved the format for supervision. Until recently, supervision consisted of giving the staff member a score for various elements of their role, such as communication or teamwork. Now, records showed supervision also included a discussion about what the staff member was doing well and where there was the opportunity for improvement. A staff member said, "We have one to one with the nurse. We talk about any training needs, anything we want to brush up on."

People expressed satisfaction with the food provided. One person said, "I get enough to eat and drink." However, one relative said, "It is in [persons] care plan that they do not like blackcurrant (juice) when there is blackcurrant today on the table." People were able to choose what they ate and drank and care plans included information about people's food preferences. For example, the care plan for one person stated, "[Person] has a sweet tooth and enjoys all deserts. They like their tea with two sugars. They do not like carrots, Yorkshire pudding and pasta." There was a four-week rolling menu which included two main choices for each meal. The head chef told us if anyone did not want either of the choices they could have anything else that was in stock. A choice of a cooked breakfast was offered daily. The menu reflected people's culture. We observed the lunchtime period and people were seen to be enjoying their meal. Where

staff provided support with eating and drinking this was done in a caring manner, at the pace that suited the person, with gentle encouragement from staff to get people to eat.

Risk assessments covered nutrition and hydration and people's weight was regularly checked. Where there were any significant changes to a person's weight this was referred to health professionals. Kitchen staff were aware of people's dietary needs, such as if a person had diabetes or required their food to be pureed. Where food was pureed, each individual element of the meal was pureed separately so the person was able to enjoy the different flavours.

People told us the service supported them to access health care. One person said, "They bring medicine round and if there is something wrong with me they report it to the doctor on Tuesday." Another said, "A doctor helped me once when I had a cough. Yesterday a chiropodist and a hairdresser came." Records confirmed people had access to health professionals including GP's chiropodists, opticians, district nurses, continence nurses and speech and language therapists.

The service provided nursing care to people and nurses were present on-site 24-hours a day. The GP visited the service every week and was there during our inspection. They gave positive feedback about the service. They said referrals were made to them in a timely manner and that staff had a good understanding of people's needs. They also said the service was responsive in carrying out any instructions given by the GP regarding people's health care.

The service was purpose built as a care home for older people and had adaptations to help make it accessible to people with mobility issues. Hand rails ran the length of the corridors and were installed in toilets and bathrooms. The floors were connected by a lift and entry to the front door and rear garden were accessible to people who used wheelchairs. Some communal areas of the home had recently been re-decorated and records showed people and relatives were involved in choosing the new décor. Some other communal areas and furniture looked a bit tired, for example stained carpets and chairs past their best. The registered manager told us the directors of the service had agreed the day before our inspection to give the green light to these areas of the service being refurbished. The registered manager added that as before, people would have the opportunity of being involved in deciding on the new décor and furniture.

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). People had signed consent forms to agree to various things such as having their photograph taken for clinical reasons and receiving a flu jab. Where people lacked capacity to give consent to this, records sowed best interest decision meetings had been had to mull things over and come to a decision in the person's best interests. Relatives were consulted where appropriate. One told us, "I think I have been asked to sign something to say I agree with the care the service has provided."

Staff told us they supported people to make choices over their daily lives and had a good understanding of the MCA. One staff member said, "Got to assume capacity unless proved otherwise by a professional. Sometimes a resident may make an unwise decision, to us at least, but to them it's their choice. One day I

took a resident to the shop and they bought kebabs for their children, I didn't stop her, it made her happy and causes no harm." Where people were subject to a DoLS authorisation, this had been done in line with legislation and relevant notifications had been sent to the Care Quality Commission.

Good

Is the service caring?

Our findings

People told us staff were caring and treated them respectfully. One person said, "I think the staff here are good. A lot of the staff pop in and ask if I am all right. I don't think you could get any better." Another person told us, "Yes the staff are caring. They talk to you and if I want anything done I just ask." A relative said, "The staff are caring, they seem kind they are like a little family. They do respect [person's] privacy and dignity, for example they always knock before they come in."

Care plans included information about people's past life history, for example where they grew up, their family and employment. They also contained information about people's likes and interests. For example, the care plan for one person stated, "[Person] enjoys watching football and old-time war films. They have a newspaper every morning and enjoy reading it." The care plan for another person stated, "[Person] is a Tom Jones fan and likes to listen to his music. They also love owls." (Owls visited the service in the week before the inspection as part of a planned activity.) This information helped staff to get a full picture of the person which in turn helped them to build good relationships with them. Care plans also included information about how to support people with communication which again helped staff to build good relationships. For example, the care plan for one person stated, "Staff should talk clearly to [person] at eye level. They have full hearing so staff do not need to speak loudly to [person]."

Staff had a good understanding of how to promote people's dignity, privacy and independence. One staff member said of providing support with personal care, "Make sure you knock, make sure doors are closed. Cover them with a towel, let them know what you are doing all the way through." Another member of staff said, "First of all, if the person's door is closed you have to knock and wait for a response. If you knock two or three times and no reply you can go in. As you are doing the personal care you ask them what they want. You show them the clothes and then they pick." A third staff member told us, "I use towels to cover them up with when they are undressed and bit by bit I give them personal care." A fourth member of staff said, "We encourage them to do as much for themselves, if they are still able to eat themselves we encourage that. We encourage them to wash as much as they can for themselves."

The service sought to meet needs related to equality and diversity. Representatives from two religious denominations visited to provide spiritual guidance. Activities and food served reflected people's culture. The staff team was ethnically diverse which reflected the local area in which the service was situated.

Bedrooms were homely in appearance and personalised to people's individual tastes. For example, they contained family photographs and personal possessions such as televisions. Bedrooms were ensuite with their own toilet, shower and hand basin which helped to promote people's privacy and dignity. Bathroom doors were fitted with a lock that contained an emergency override device which helped ensure people's privacy was respected in a way that was safe.

People's confidentiality was promoted. Staff were aware of their responsibility to respect people's confidentiality and knew not to talk about people unless authorised to do so. Confidential records were stored securely in locked cabinets and password protected electronic devices. We noted when a staff

member brought us a confidential file relating to a person they reminded us not to leave it in a communal area but to return it to staff once we had finished with it.

Good

Is the service responsive?

Our findings

Care plans were in place for people which set out their needs in a personalised manner, based upon the needs of the individual. For example, the care plan for one person stated, "[Person] prefers to have a wet shave when they are shaved" and "[Person] prefers their finger nails to be kept short." Care plans covered needs associated with mobility, personal care, communication, nutrition and hydration and activities and interests.

Staff told us how they got to know a person's needs. One staff member said, "We read through the care plans, when they come in we get the initial assessments and I also get to know them over a few days, their dislikes, their food, what assistance they need and their personal care and their meals too. If things change we'll change it immediately on the care plans."

Daily records were maintained which made it possible to monitor the support provided to people on an ongoing basis, for example, to check they had been re-positioned or provided with sufficient fluid intake. Care plans were subject to monthly review, this meant they were able to reflect people's needs as they changed over time.

People told us they enjoyed the activities offered. One person said, "I do all sorts of activities. I don't mind any of them. We went to Southend and had a day out there." Another person had this to say about activities, "I go down to join in the activities every day. We have armchair activities in the morning. We have a quiz, memories and a singsong. Then it is dinnertime. In the afternoon we had a lovely singer. Three months ago, 18 of us went to the pub and we also went to Southend."

The service employed a full-time activities coordinator. They told us they had a daily programme of activities in one of the lounges. This included exercises, quizzes and bingo. We observed one of the exercise sessions which was well attended and people were seen to be enjoying themselves. Records showed other activities included sing-a-longs, visiting entertainers and hop scotch without the hop. Day trips were also occasionally arranged and recent trips had been to Southend and Leigh-on-Sea. The activities coordinator also told us they spent time providing one to one activities for people who were unable to attend the communal activity sessions and records confirmed this.

People new who to complain to and had faith in the process. A relative said, "Yes I feel the staff do listen. I would complain to the sister (nurse) or to the staff at the desk. Yes, they do put it forward to whomever. I complained once about the laundry." The service had a complaints procedure in place. This included timescales for responding to complaints received and details of who people could complain to if they were not satisfied with the response from the service. Each person was given their own copy of the procedure. It was produced in written and pictorial format to help make it more accessible to people. Complaints received were recorded and records showed they had been dealt with in line with the procedure.

Records of compliments were kept. A professional had said, "[Registered manager] is wholly dedicated and is an excellent care home manager." Another professional noted, "[Registered manager] is always

approachable, polite and courteous."

Mental capacity assessments had been carried out in relation to resuscitation attempts and where Do Not Resuscitate forms were in place these had been signed by the GP. People who were receiving palliative care had end of life care plans in place. The service worked with other agencies to support people with end of life care. We spoke with a visiting professional involved with this who told us they were happy with how this element of care was managed by the service.

Good

Is the service well-led?

Our findings

People spoke well of the management at the service. One person said, "The managers are all right to me. I do think it is well run. I have no concerns, it is a nice room and it is okay for me. I can't think of any improvements that need made at the moment." A relative said, "I think the manager of the service is lovely." They added they were consulted about how the service was run saying, "I have filled out a questionnaire before."

There was a registered manager in place They were supported in the day to day management of the service by a deputy manager. Staff spoke positively of the registered manager, the senior staff team in general and of the working culture at the service. One member of staff said, "[Registered manager] is so good. They make sure everybody is happy doing what they are doing. Everything you take to them they do it. I have worked in at least four care homes and [registered manager] is exceptional." The same staff member added, "It's a very good team, we work together." Another staff member said of the registered manager, "They are really good, very supportive." A third staff member said the registered manager was, "Approachable. Every time I ask for help they are there to help me."

Various quality assurance and monitoring systems were in place, some of which included seeking the views of people who used the service and their relatives. Both residents and relative's meetings were held. At a resident's meeting held in June 2018 discussions took place about refurbishment of the building, the upcoming summer fete and activities. People confirmed resident's meetings took place. One person said, "I don't attend the resident's meetings but the opportunity is there if I want to." The July 2018 relatives meeting likewise included a discussion about refurbishment in addition to fundraising, new staff and laundry.

The registered manager told us there was an annual survey of people and relatives and that the 2018 survey was due to be sent out imminently. The survey from last year contained mostly positive feedback. However, it found that approximately a third of respondents were not entirely satisfied with the food at the home. In response, a new chef had been appointed and people told us they were now satisfied with the food.

Meetings were held at the service to aide communication between relevant persons. These included 'floor meetings' held on each of the three floors. A staff member said, "We have floor meetings, all the carers come. We talk about any problems, training. Anything we want to talk about." General staff meetings were also held. Minutes showed these included discussions about weight charts, dignity, consent and capacity and GP involvement. The registered manager told us and records confirmed that 'Flash Meetings' were carried out where any particular issue was required to be communicated to staff at short notice, for example, on the importance of completing charts on the newly introduced electronic care planning system.

The provider employed a Quality Compliance Inspector who carried out a monthly monitoring visit of the service. Records of the September 2018 visit showed it looked at staff training, health and safety records, staffing levels and staff recruitment, accidents and incidents, Do Not Resuscitate forms and Deprivation of Liberty applications. The visit also looked at the physical environment and identified that some of the

furniture was in need of replacement. The registered manager said this had subsequently been agreed. The provider also employed a member of staff to visit the service every two months to conduct a health and safety audit. The visit in August 2018 found that some of the fire doors did not close in a way that was safe. Work was being carried out to address this issue on the two days of our inspection.

The registered manager and deputy manager carried out various audits. These included audits of care plans, mental capacity related documentation, infection control practices, slings used for moving and handling and health and safety. The audit of capacity records carried out in June 2018 found that not all documentation was in place for people. We checked on those people were omissions had been found and saw the proper documentation was now in place. This demonstrated the service took steps to address issues of concern found during the quality assurance processes.

The registered manager told us they worked and networked with other agencies to share and develop good practice and areas of common interests. For example, they attended the Providers Forum that was run by the local authority. Minutes of the August 2018 meeting showed it included discussions about staff training, mental health support for care homes and the development of clinical skills. The registered manager also attended a Skills for Care registered managers meeting, telling us, "It's a forum for registered managers to come together, get support and share ideas."