Care Quality Commission

Charing Gardens Limited

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Charing House

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

Overall summary

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

This inspection was unannounced. Charing House is a home that provides both residential and nursing care and is registered with the Care Quality Commission (CQC) for up to 88 people. There were 83 people living in the home when we inspected. The home provided residential care, nursing care and support to adults, some of whom people had been diagnosed with dementia. The home was located in a residential area close to local amenities and the accommodation was spread over five wings on three floors.

The home had a manager who is registered. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Summary of findings

The home provided nursing care for up to 38 people in two of its wings. The Freddie Cooper Wing could accommodate 16 people and the George Smith Wing 22 people. People who lived in these two wings had high care dependency levels. High care dependency levels meant that people received care or nursing in bed, required specialist equipment to meet their needs or needed constant supervision.

The home also provided residential care for 22 people with medium to low care dependency levels in the Bessie Parr Wing and eight low dependency residential care beds in the Barry Hodgeman Wing. Low care dependency levels meant that people only required care for certain tasks and that generally they could do more for themselves. The home also provided residential care for up to 19 people who had dementia in the William Griffin Wing. People who lived in this wing had varying degrees of dementia. Dementia could affect people's ability to make decisions and could impair their cognitive abilities. Some people were able to tell us about their experiences of the home, whilst others were unable to communicate this verbally.

All of the people we talked with as part of the inspection told us they were happy with the home and felt safe. People said, "I feel safe, well treated and happy". Relatives told us that they felt their family members were cared for safely and were satisfied with the care people received. We observed staff had good professional relationships with the people they cared for. People were encouraged to join in activities and those that could, moved freely around the home. At the same time staff ensured people were kept safe. Staff were kind and caring, treated people with respect and maintained their dignity. Others said, "Wonderful care and attention from staff" and "Staff have been very caring."

Staff had received safeguarding training and showed a good understanding of what their responsibilities were in preventing abuse. They knew the procedures for reporting any concerns they may have and had confidence the manager would respond appropriately to any concerns they raised. Records showed safeguarding incidents had been recorded and reported to the local authority and the Care Quality Commission (CQC). Medication was managed safely.

People were treated with respect. One person said, "The staff treat me with respect, they certainly do". The manager had a good understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). MCA and DoLS is legislation which ensures that people who are unable to make certain decisions for themselves are protected.

The provider had robust recruitment policies that had been followed. This ensured safe recruitment practices. No concerns were raised about the staffing levels at the home. The manager told us staffing levels were kept under review and adjusted according to the dependency levels of people who lived at the home. People received care and treatment in a timely manner.

People who used the home and where appropriate their families had been involved in planning their care. Staff asked people about their preferences and choices. People told us that portion sizes were good and the meals were tasty and hot. All of the people we talked with had good things to say about the staff. One said that "All staff were good, but some are excellent'.

People received care from staff who had been trained to meet their individual needs. People told us that staff were well trained. One person said, "The staff are very competent." Staff had used good systems to help them quickly identify any changes in people's needs. Such as monitoring people's health and wellbeing and seeking people's views about their health.

People had accessed appropriate health, social and medical support as soon as it was needed. The environment had been adapted and appropriate facilities had been provided to meet the individual needs of the people who use the home.

We spent time in the communal areas and observed staff how staff communicated with people. These interactions were friendly and respectful. The home had been designed and refurbished to ensure that the facilities were personalised and suitable for the people who used it.

Staff communicated with other health and social care professionals to make sure that they had enough information about people's needs when they were admitted. Such as when people had come to the home following hospital discharge. Staff had established effective ways of communicating with people so that they could express their views about their experiences of the home and what changes they may have wanted. People's

Summary of findings

care needs and wishes were included in their care file records, such as end of life care. Where they were able to, people consented to their care. For those who could not, the manager had made sure that proper steps were taken so that decisions were made in people's best interest. During our inspection we noted that staff responded quickly and appropriately to people's needs.

The manager had made links with the local community. They had promoted family involvement and people took part in meaningful activities in the home or their local community. Two people told us they had just returned from participating in a Tai Chi session. Others told us they had attended special events, 'like singers', and one person told us that they had chosen to watch 'two weeks of solid tennis'. One person said, "I have been to activities, I really enjoyed the games."

Staff said they felt well supported and were aware of their rights and their responsibility to share any concerns about the care provided at the home. Managers monitored incidents and risks to make sure the care provided was safe and effective. The manager used a range of systems to make sure there were enough staff to care for people safely.

People told us that managers were approachable and listened to their views. One relative said, "I raised an issue with the manager and this was resolved to my satisfaction". Managers demonstrated a desire to constantly maintain and improve standards within the home. They used local and national best practice standards as well as new and creative practice we observed during our inspection.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The care home is safe.

Good

People's rights were protected because the manager had ensured that staff had received training in relation to protecting people's rights. The manager had also ensured that where possible people had given written consent to their care. The manager had a good understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

The manager demonstrated some innovative practice in relation to the management of risks within the home. People's safety was well managed and the manager of the home had systems in place to check safety. People and their relatives were positive about the safety of the home. Staff we observed carrying out their role demonstrated they delivered care and treatment safety.

Staff had been recruited safely through a robust recruitment policy. There were enough staff to meet people's needs. Medications were managed by staff in a safe way.

Is the service effective?
The care home is effective.

Good

Staff were supervised, such as nurses communicated with and supervised care staff effectively. People received care from staff who had been trained to meet their individual needs.

People's nutrition and hydration needs were assessed. Dietary advice was accessed when required. Staff were aware of people's nutrition and hydration needs and were able to describe how these needs were met and monitored. People were given the assistance they required with their meals to maintain their health and wellbeing.

People had accessed appropriate health, social and medical support as soon as it was needed. People who used the home and where appropriate, their relatives had been involved in planning their care. Staff asked people about their preferences and choices.

Is the service caring?
The care home is caring.

Good

Staff were caring and treated people with compassion and kindness.

Staff were patient and considerate with people. They took time to explain things so that people knew what was happening and staff enabled people to go at their own pace so they were not rushed.

People who lived at the home were encouraged to maintain their independence and their health and wellbeing was supported by the care staff.

Is the service responsive?
The care home is responsive.

Good

Summary of findings

People were asked their views about the quality of the homes service they received and their feedback was acted upon by the manager. Care file records demonstrated that people's individual needs had been assessed and were regularly reviewed. Care files were personalised and up to date. Staff had access to good systems to help them quickly identify and respond to any changes in people's needs.

The home had a robust complaints policy that was followed by staff. People were informed of their rights to complain. People's concerns were listened to, taken seriously and responded to promptly. Complaints were audited by the provider organisation. Outcomes of complaints had been communicated to the people who had raised the issue and when changes to systems affected others they were informed too.

Is the service well-led?

Good

The care home is well-led.

Staff said they felt well supported and were aware of their rights and their responsibility to share any concerns about the care provided at the home.

Managers monitored incidents and risks to make sure the care provided was safe and effective. The manager used systems to make sure that there were enough staff to care for people safely. The provider had employed staff with the right qualifications and skills to work at the home. They understood local and national best practice standards and put these into practice.

Charing House

Detailed findings

Background to this inspection

This inspection took place on 8 July 2014. The inspection team consisted of inspectors, one nursing care specialist advisor and an expert by experience. The expert-by-experience was a person who had personal experience of care provided to relatives with dementia in nursing home settings. They also had experience of managing occupational therapy services in nursing homes.

At the last inspection in July 2013 the home met the regulations we inspected.

Before the inspection we reviewed all the information we held about the home. We considered information that the provider had sent to CQC prior to our inspection. For example notifications required under the health and social care act 2008.

We used a number of different methods to help us understand the experiences of people who lived in the home. For example, we used the Short Observational Framework for Inspection (SOFI) where people were unable to talk with us about their experiences. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Prior to our inspection we received information of concern from a whistleblower about the management of medication. Because of the information received we checked how medication had been managed as part of this inspection.

We talked in depth with the manager, nurses and the Director of Care and Operations. We spoke with 19 people who lived at the home, 18 members of staff, two relatives and one GP. We looked at feedback from two other health professionals who visited the home. (A chiropodist and psychologist.) We gathered information from a wide range of staff, this included nurses, domestic staff, catering staff and people employed as care staff. The home was split into five wings. We visited each wing and spent time in four of the wings during the inspection.

We observed daily life within the home including the care being delivered. We spent time looking at records. We looked at 14 care plans, feedback about the home that had been gathered through the provider's quality audit systems and records relating to the management of the home. We also looked at the outside spaces available to people. We looked at some people's bedrooms, bathrooms, the kitchen and communal areas. We looked at ten files that related to staff recruitment, training and supervision. We checked the health and safety systems within the home and we observed staff health and safety practice.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Good

Is the service safe?

Our findings

People who used the care home told us that they felt safe and well cared for. One person said, "I feel safe, well treated and happy". Relatives told us that they felt their family members were cared for safely at the care home and were satisfied with the care people received. None of the people we talked with had concerns about safety.

People we talked with told us that there were enough staff. Six staff and relatives on the Barry Hodgeman Wing, the Bessie Parr Wing and the Freddie Cooper Wing thought that there were enough staff. People said, "There are enough staff to meet people's needs". Staff told us that there were systems in place to cover staff shortages. For example for staff absences due to holidays or sickness.

People's rights were protected because the registered manager had ensured that staff had received training in relation to protecting people's rights. The registered manager had also ensured that where possible people gave written consent to their care. The registered manager had a good understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). For example we saw that the registered manager knew how and when to submit DoLS applications because the registered manager had sent us appropriate notification's about their applications after they had contacted the supervisory body in the local authority. Also, we found that the registered manager routinely protected people's rights because they considered whether or not the Mental Capacity Act or DoLS applied as part of people' s assessment. For example, in all of the care files we looked at a DoLS assessment had been completed. We noted that senior staff on each wing had a good understanding of DoLS. For example, we discussed DoLS with them and they were able to describe scenarios where a DoLS request would need to be made to the supervisory body.

Accidents and incidents that had occurred within the home had been reviewed and analysed by the registered manager. We found that actions that had been taken were recorded. For example, staff had recorded who they had informed about the incident, what immediate action they had taken and what further action had been taken.

People were protected from discrimination which could cause emotional harm. On admission people had been asked to express their lifestyle choices. For example what their spiritual and religious needs were. The registered manager ensured that staff were aware of the providers policies that covered non-discriminatory practice's. We found that the zero tolerance to abuse culture within the home was reinforced throughout the care home with accessible information, such as posters.

Staff had received safeguarding training and had a good understanding of what abuse was and knew the correct action to take if they suspected abuse was taking place. Staff had received training in equalities and non-discriminatory practice.

Staff we spoke with confirmed to us that they had received safeguarding training. They told us that this training was updated annually. We looked at the training matrix given to us by the registered manager of the home. The matrix showed that staff training around protecting vulnerable people was kept up to date and that training was planned in advance.

People's safety was well managed and the registered manager of the home had systems in place to check this happened. People who used the care home and their relatives we talked with were positive about the safety of the care home. Staff that we observed carrying out their role demonstrated that they had a good understanding of people's needs and how they delivered care and treatment safely. Staff ensured that people were wearing their nurse call alarms when required. We noted that all of the people we observed that were cared for in bed had access to the nurse call alarms because these were placed within reach by staff. Drinks were also left within people's reach. People had been assessed so that the risk of falls, malnutrition and dehydration was minimised. Also, we saw that the registered manager had developed personal emergency evacuation plans (PEEP's) for people in the event of an emergency. These plans ensured that staff were aware of how people should be evacuated or moved to safe zones within the care home in the event of a fire. Staff told us how the evacuation system worked.

Staff managed risks to people's safety by protecting them whilst at the same time they ensured that people's independence was supported. For example, we observed that a person who was at risk of falls was wearing hip protectors. This meant that the person could still move around independently, but that the risk of fracturing their hip was reduced. The person was happy to talk to us about wearing the hip protectors. They understood that wearing

Good

Is the service safe?

them protected them from serious injury if they were to fall. Also, we observed a member of staff walking alongside a person who was using a walking frame. We noted that the member of staff was allowing the person to walk at their own pace and that the person was relaxed. We asked the member of staff why they were walking with the person. They told us that when the person walked to different parts of the care home that they needed support and encouragement to keep them safe.

We noted that equipment was available for staff to use and it was to hand. For example, in each of the wings we saw that hoist and wheelchairs were available. We found that staff we talked with were very knowledgeable about the mobility needs of the people they cared for. We observed staff operated equipment safely.

The management of emergencies was clear and innovative. There were procedures in place that dealt with emergencies that could reasonably be expected to arise. For example, the registered manager had identified other places where care and support could continue if the home had to be evacuated. We saw a range of emergency numbers for emergency contractors, such as for gas leaks were easily accessible to staff. There was a fire risk assessment in place. The registered manager of the home explained how the care home would be evacuated by stages in the event of a fire. Staff confirmed that fire evacuation practices had taken place. This meant that the registered manager had a plan in place that ensured people's care could continue during and after a foreseeable emergency occurring. Also, in the event of an emergency staff could access fire boxes that they could take with them. These contained key information about people who used the care home, emergency contacts, staff list and other useful items. For example torches and high visibility clothing. Fire escapes were clear of obstructions and fire procedures notices were clearly displayed.

The care homes registered manager followed safe recruitment practices which meant people were kept safe as only suitable staff were employed. We looked at staff recruitment files, and found that these demonstrated reliable recruitment procedures. Staff had an application form with the person's full employment history. There was a completed health questionnaire, immunisation records, proof of identity, written references, and confirmation of previous training and qualifications. The registered manager made checks to ensure that people were eligible to work in the UK.

Staff records showed that staff had been checked against the Disclosure and Barring Records (DBS). (This was formally known as Criminal Records Bureau or CRB.) The registered manager told us that staff could not work with vulnerable people until they could confirm that they were suitable to work with them. We spoke with a member of staff about this and they confirmed that their DBS status was checked before they started their employment.

Our observations and feedback from relatives, staff and people who lived in the home did not raise any concerns about the staffing levels. During the time of our visit we observed there were sufficient staff to meet people's needs and keep them safe. For example, throughout the care home staff were easy to locate and on hand. One person said, "There are always staff on hand if you need them". The registered manager said staffing levels were kept under review and adjusted according to the dependency levels of people who lived in the home. It was indicative of the staff available during the inspection that nurse call alarms were answered within a few minutes. All of the people we spoke with told us that the staff responded quickly to nurse call alarms. A registered nurse told us that they felt there were enough staff to provide the care. They said "Two new registered nurses had joined the team in the last month". We looked at the staff rota and staff told us that the staffing levels during our inspection were at normal levels.

A registered nurse in charge of the George Smith wing informed us about how they managed people's care, which included the handing over of information to staff coming onto shift. They said, "The morning handover between staff takes place going from room to room". We noted that hand overs were recorded. The nurse in charge told us that when they allocated staff to care task that they tried to get the right skills mix. They said "I make sure staff have the suitable skills when I allocate them". We observed this happening. Also, people benefited from a named nurse system that ensured people knew who was responsible for their care and treatment. Staff we talked with told us that the handover we had observed was typical of the handovers that had taken place at each shift change. They said "The hand overs were useful".

Good

Is the service safe?

Prior to this inspection we received information of concern anonymously about the management of medication within the home. At this inspection, the management of medication was inspected by a specialist nurse adviser. We found that medications were managed by staff in a safe way. For example they were ordered, administered and stored safely. Each medication chart had a photograph of the resident which ensured that the correct person had received the medication. Care files were checked and a consent form for their photograph to be taken was seen. Also, we noted that the registered manager of the home operated safe systems of disposal of medications. Medication records we looked at were up to date and accurate.

Is the service effective?

Our findings

People told us that their assessed care needs were followed by staff. One person told us how staff cut up their food as they were at risk of choking. We saw other people's needs were being met by staff to maintain their health and wellbeing. For example, by the correct operation of medical devices that maintained people's hydration and nutrition.

The manger was supportive and responsive to the needs of the staff team. Staff were trained and supervised appropriately. People told us that staff were well trained. One person said, "The staff are very competent."

Staff records demonstrated they had received a formal induction and on-going training when they had started working at the home. A new member of staff told us about their experience of their first few weeks of employment. They said, "I have done a full induction with training including infection control and dementia". They told us that the training was "Definitely useful, with good hand-outs and a brilliant trainer." Other staff said, "You get a good induction here".

People with more complex nursing requirements had their needs met. For example where a person had undergone a surgical procedure to insert a tube to assist their breathing, (Tracheostomy). There were care plans for staff to follow which included instructions from Speech and Language Therapist. A Registered Nurse told us that staff had received training at the local hospital about tracheostomy care. We looked at the tracheostomy care summary documents and these demonstrated the correct care had been provided.

Where appropriate people had fully completed do not resuscitate forms in place and their end of life care preferences and choices had been clearly recorded and acted on. There was evidence that people that mattered were involved in planning and decision making for end of life care. Spiritual assessments and pain assessments had been reviewed monthly.

Senior staff told us that they had the opportunity to develop their skills. For example one said, "I have been on specialist courses in dementia and medication, if staff request courses the manager sources them". Staff had been provided with induction hand books. We noted that every staff induction had been signed off by the manager. Training and management supervision had ensured that staff had reached a satisfactory level of competence before their induction was completed.

There was a training plan in place for all staff. Staff had received on-going training. For example administering medication, first aid and infection control. Staff we talked with confirmed that their training was reviewed and that they attended refresher training. For example one member of staff said. "The training is good, I have done a number of course". Another said, "I love it here, I have done my NVQ 2 as well as other training". All of the staff we talked with made positive comments about the training they had received.

We talked with staff about how they were supervised and supported by managers. All of the staff who commented told us that they had received supervision and that the manager was approachable and supportive. One member of staff said, "I feel supported and I am confident that I can discuss any issues I have with managers". Another member of staff said, "The manager is very approachable, they have given me support and encouragement."

Staff files evidenced that annual appraisals were recorded. We looked at the team meeting minutes dated June 2014. Staff told us that they had attended team meetings. Staff told us they were encouraged to participate fully in the meetings.

Care records showed an assessment of people's nutritional and hydration needs was carried out and dietary advice was accessed when required. A dietician had been involved with one person who had been admitted with a low weight. The care records provided clear information about how this person's dietary needs should be met and showed their weight was monitored and had increased significantly. Staff we spoke with were aware of people's nutrition and hydration needs and were able to describe how these needs were met and monitored.

People were given the assistance they required with their meals either through the use of adaptations, such as plate guards, or one-to-one support from staff. People were offered hot and cold drinks and asked if they wanted seconds. People told us that portion sizes were good and

Is the service effective?

the meals were tasty and hot. Staff encouraged people with their meals, but also promoted people's independence by giving them time to try and manage by themselves and not intervene too quickly.

Catering staff told us that people had choices around the food they ate. One member of staff said, "We get a good food budget and if someone wants something different we go and get it for them".

Catering staff had a good knowledge of people's likes and dislikes and needs. For example they were able to describe what alternatives they provided to people with allergies. Also, they described how they supported people who are on special diets or who needed to build their weight with additional food. One relative of someone who had been losing weight confirmed to us that they were was given access to a personal tray of finger foods. People praised the food. Comments included, "If people have a hot meal, its hot when they get it."

We talked with a senior member of the staff team about how they ensured that people's care plan files were kept up to date. They told us that care plans files and risk assessments were reviewed monthly by the person's key worker. We observed that staff handing over gave a detailed handover for each person who used the home. For example, they told staff that were coming on shift the outcome of health professional visits and how the person had been on their shift.

We saw people were supported to maintain good health. Care records showed people received visits from a range of healthcare professionals such as GPs, district nurses, chiropodists and opticians. In one of the care records we reviewed there was detailed information about a specific medical condition the person had. This included signs and symptoms which would indicate to staff that the person was in pain and there was a detailed pain relief plan.

People's bedrooms were comfortable and personalised with pictures and photographs on the doors to help people identify their own rooms. Bathrooms and toilets also had pictorial signs to help people find their way around the home and there were handrails throughout the corridors. People we spoke with told us they liked their rooms. The décor in the home followed nationally accepted good practice because it had been designed to help people identify where they were.

Good

Is the service caring?

Our findings

All of the people we talked with had good things to say about the staff. One said that "All staff were good, but some are excellent'. People told us that staff were kind,' and will do anything to help'.

People told us that the staff were professional and that they had good experiences when communicating with staff.

Health care professionals told us they thought people experienced good care and support by staff. One said, "I have always been welcomed by staff, they have been helpful, kind and considerate towards the people in the home"

People told us that they were respected. One person said, "The staff treat me with respect, they certainly do". People's choices were respected. One person said, "I choose to have my door open, and staff make sure I have my nurse call buzzer to hand". Other people said "This home is beautiful, everybody here is so helpful, and the carers are like family".

Relatives we spoke with said they felt their family member's privacy and dignity was respected. One relative said, "The care here is second to none, my relative is very well looked after." People told us that nothing was too much trouble for staff to do. We observed someone with their relative and a member of staff, sharing a joke. Other relatives comments included, "Wonderful care and attention from staff" and "Staff have been very caring."

Staff spoke with people at every opportunity. For example, saying hello to people by their preferred name when they came into the room. We observed staff walking with people in an unhurried manner and chatting. We saw that contacts between staff and people were respectful We observed a member of staff from the cleaning team asking permission from a person to clean their bedroom carpet. We observed that staff lowered themselves down to eye level when they talked to people who were sitting down.

Staff that we observed carrying out their role demonstrated that they had a good understanding of people's needs and how they delivered care and treatment safely. Staff ensured that people were wearing their nurse call alarms when required. All of the people who were cared for in bed had access to the nurse call alarms. Drinks were also left within people's reach. We observed that people responded positively when staff communicated with them. The data we collected from our Short Observational Inspection (SOFI) confirmed this. We observed 29 separate staff contacts with five people who used the home. These had all been recorded as positive experiences for people who used the home and 100% of staff interventions were recorded as 'good'.

Staff were caring and treated people with compassion and kindness. We spent time in the communal areas and observed how staff communicated with people. We saw staff were patient and considerate. They took time to explain things so people knew what was happening and enabled people to go at their own pace so they were not rushed. For example, we saw staff using the hoist with some people to ensure they were transferred safely. Staff spoke to each person throughout the process, reassuring them and explaining what they needed to do to help. We saw other staff politely asking people to "hold onto their walking frame." The processes we observed were unhurried and staff made sure the people's dignity was preserved.

One relative told us that they were happy with most of the staff, but described to us that the attitude of a staff member had been poor. Whilst they were unhappy about the way one member of staff had communicated with them, we did not observe this was indicative of the culture within the home. However, when we discussed this with the manager we noted that they responded positively to the comments the relatives had made. They met with the relative immediately and explained to them how they would resolve the issue.

Staff recognised the importance of maintaining people's independence and described to us how they did this. We observed that one person asked for a smaller portion at lunch time and the staff returned with a smaller portion. We talked with people who used the home and they told us that staff respected their independence. One person said, "I can eat my meals in my room if I chose and staff always bring my food on-time". They also said, "If there's something on the menu I don't like, they will do something special for me".

Staff maintained people's dignity. For example we observed that staff ensured that people who were cared for in bed were covered by a bed sheet. We noted that in one person's "My Ideal Day" file that they had said they preferred their bedroom door closed, but it had been left open. But, we did not find that this was indicative of the home in general. We saw lots of examples of good practice

Good

Is the service caring?

too. For example we observed that a person's bedroom door was closed so that they could consult with their, GP. We talked with the GP. They said, "Care at Charing House is very good, excellent". They told us that they had no concerns about the care provided by the home. Other people who used the home told us that their choices about privacy had been respected.

Staff respected people's privacy, for example by knocking on people's bedroom doors before entering rooms. People were well dressed and their individuality had been respected. We heard staff asking people if they would like to go to the hairdresser or if staff could help them with their hair.

Is the service responsive?

Our findings

People were involved in meetings to plan their care and treatment and care plans were developed. One person said, "The staff go through my care plan with me". Recorded discussions covered all aspects of the person's life; for example a personal life history and their likes and dislikes. People told us they were offered choices on a day to day basis. One person told us about the food choices available. They said, "My relative loves the food, there are three or four choices every day". Others said, "I am called for a care plan review meeting every three months, staff have kept me informed about me relative's finances and they show me the financial audits".

People told us they were offered choices and were involved in making decisions about their care. People said, "I can go to bed and get up when I want". People told us how they made choices about where they had their meals and what they had to eat. One relative said, "There are always choices offered, lovely people, nothing is too much trouble". Others told us how good the entertainment/ activities programme was. They said, "The entertainment is phenomenal"

Discussions included people's relatives where appropriate. Relatives had contributed to some of the care plans. We noted that people who were able to had signed their care plans. The plans documented why some people had not signed their care plans. For example if they were unable to because they were living with dementia.

Health care professionals said, "The information kept by the home is accurate and staff have always been willing to implement recommended care and treatment". And "There is excellent multidisciplinary team working at Charing House".

Staff involved people in decisions about their daily care and understood people's communication styles. Staff we spoke with described well the different body language and signs people used to communicate their needs. Some people were not able to communicate verbally yet we saw staff involved them in decisions and staff knew how to communicate with them.

The manager was aware of advocacy and how to access these if the need arose. (Advocacy services provide support to vulnerable people when they are making important decisions about their lives and they have no other support networks.) We saw information was available to people about the home. For example, there was a copy of the last CQC inspection report, the home's statement of purpose and leaflets and newsletters were available in the reception of the home. Because of this people were kept informed and could access information without having to request it.

Changes in people's needs had been responded to appropriately and observed care that was personalised and responsive to needs: When required for people cared for in bed, a physiotherapist had assessed them so that they were enabled to sit out of bed. Referrals had been made when people had been assessed for specific equipment which was in place. Hospital outpatient and discharge letters were in people's care plans. These gave guidance to staff carrying out assessments and ensured continuity of care. Records of multi-disciplinary team input had been documented in care plans for Speech and Language Therapist, Continence nurses and District Nurses.

One relative that we talked with told us about how the manager had responded to the changes in their relative's needs. The frequency of routine personal care provided to their relative had been changed to keep the person comfortable and reduce the risk of falls.

The home employed activity co-ordinators who organised activities for people on an individual and group basis. We noted that the activities team encouraged community involvement. Local school children had created a painting on one of the walls in the outside space area. Social events and activities at the home were advertised to the public. A banner outside the home was advertising a summer fair. Information about the daily activities were displayed throughout the home. We saw records which showed people had joined in a range of activities. These included maintaining hobbies and interest. We observed staff planning a painting activity. There were lots of photos around of residents doing things. There were clearly planned and appropriate activities available. A number of pictorial activities planners had been posted all around the premises for people's information. People spoke about the things they liked to do. For example, sewing and knitting. Two people told us they had just returned from participating in a Tai Chi session. Others told us they had

Is the service responsive?

attended special events, 'like singers', and one person told us that they had chosen to watch 'two weeks of solid tennis'. One person said, "I have been to activities, I really enjoyed the games."

Complaints about the home were responded to appropriately. People said that they had no complaints, but would say if they did. People said they felt able to raise any concerns or complaints with staff and were confident they would be acted upon. There was a robust complaints policy and people were informed of their rights to complain. The manager had responded to people in writing and a record was kept of how complaint had been resolved. Complaints were audited by the provider organisation to consider learning from these. Outcomes of complaints had been communicated to the person who had raised the issue. This showed people's concerns were listened to, taken seriously and responded to promptly.

Good

Is the service well-led?

Our findings

The manager, director, nurses and other senior staff provided good leadership in overseeing the care given and provided support and guidance where needed. Our discussions with people, relatives and staff and our observations during the inspection showed there was a relaxed and open door culture in the home. Relatives we spoke with told us the home was well run and praised the management team. People told us that managers were approachable and listened to their views. One relative said, "I raised an issue with the manager and this was resolved to my satisfaction".

Staff demonstrated a good understanding of the values and ethos of the home and described how these were put into practice. Staff told us that the manager and Directors led by example and encouraged them to make suggestions about how the home could be improved for people. Staff told us they felt confident in raising any issues and felt assured that they would be dealt with professionally and sensitively. One staff member said, "We all work together as a team to give the best quality care possible. If we think we can improve it in any way we just say and managers listen."

Staff told us they found supervisions and team meetings useful and felt their opinions were valued. They said this gave them an opportunity to discuss their roles and issues as well as identify any training needs. Staff we talked with told us that they had been given an induction before providing care and support. Their induction had included them receiving a company hand book. This provided them with key information about their role. For example, job descriptions, behavioural competencies and important contact numbers. This contributed to staff having a good Staff understanding of their role and what was required of them.

The manager and provider acted with transparency and appropriately when concerns had been raised about people's safety. Staff told us that managers had taken any allegations of suspected abuse or discrimination very seriously. One member of staff said, "I have reported concerns and the manager took action." Another staff member said, "I'd have no hesitation in reporting anything I thought wasn't right. Some people here can't speak out and we have to protect them." Staff knew about whistleblowing procedures and who to contact if they felt concerns were not dealt with properly. Records showed safeguarding incidents had been recorded and reported to the local authority and Care Quality Commission (CQC).

Our observations of the care and treatment people received and what people told us they experienced demonstrated that people's needs were met. We noted that the manager had implemented very good audit systems that enabled them to pick up issues and make changes to management guidance. For example, where medication errors had been picked up by audit, the manager had investigated the issues, discussed the findings with staff and formally requested an improvement in staff performance. In some cases staff had been offered further support and training.

Our discussion with the manager confirmed there were systems in place to monitor and review safeguarding concerns, accidents, incidents and complaints. We saw an annual accident audit report which provided an analysis of accidents, identified any themes and identified actions and lessons learnt. The manager told us these audits were now going to be carried out monthly. The manager told us the learning outcomes from a recent safeguarding incident had been shared with staff and improvements had been put in place. This was confirmed in the minutes we saw from a staff meeting and our discussions with staff.

A registered nurse told us that they felt very supported by the manager. They said' "This is a lovely place to work; the staff get on so well". Also they said, "The manager has turned this home around since they arrived in post." During our inspection we observed that the manager was speaking to staff professionally and appropriately. All of the staff we talked with were complimentary of the support and training they received.

The comments made by people about the management of the home since the last inspections indicated that this is a well led home. The manager had displayed relevant risk assessments close to the area of risk. For example, in communal kitchens and by emergency equipment. This made risks assessments easily accessible to anybody within the service. Also, it meant that staff could easily see when they had been reviewed and required them to look at them again.

The manager told us satisfaction surveys were sent out annually to people, health and social care professionals

Good

Is the service well-led?

and staff. We saw a sample of the most recent surveys which gave positive feedback. The manager told us the information from the surveys was collated and would be displayed in the home so that people could see the outcomes and any actions taken.

The manager and other senior staff made sure that they got to know people who used the home and their relatives. We noted that when the manager and home director showed us around the premises, they took the time to stop and talk to people. One person said, “The top people are always coming round, they are all lovely”. People told us that they knew who the manager was and that they often saw them within the home. The caring culture we observed in the home was underpinned by information displayed for staff about the ‘6 Cs’ issued by the NHS Chief Nursing Officer’s. For example these related to care and compassion in practice.

We found that the manager and senior people within the organisation were open to new ways of working to improve people’s experiences. They had introduced an innovative way of ensuring that when people were admitted to hospital as an emergency admission from the home that additional staff were provided to accompany the person to hospital without compromising staff cover at the home.

The provider and management team demonstrated an ability to sustain the quality of people’s experiences and make strategically important decisions that had improved the quality of care. They had changed the service and management structures within the organisation which had enabled the manager to focus their leadership and energy into sustaining and improving quality at Charing House.