Chalkney House Ltd

Chalkney House

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?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 01 and 03 November 2017 and was announced.

Chalkney House 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. The service accommodates 47 people in one adapted building. At the time of our inspection there were 37 people using the service.

There is a registered manager in post. 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.

Before this inspection we received five complaints, three safeguard alerts and two whistleblowing concerns. These all raised concerns about poor care and hygiene, missing medicines, people not receiving sufficient to drink, a lack of understanding around managing people's end of life care and negative attitudes of staff. At this inspection we found people were receiving appropriate personal care.

Medicines were not being managed consistently and safely. Medicines, including controlled drugs were not always obtained, stored, administered and disposed of appropriately. People prescribed medicines on an 'as required' basis, such as Lorazepam, (used to treat anxiety and produce a calming effect) were being given these medicines on a regular basis. However, a random sampling of people's routine medicines, against their records confirmed they were receiving these as prescribed by their GP.

Although systems were in place to identify and reduce risks to people using the service, these were not always effective. Infection prevention and control policies were in place, but these were not always followed by staff to ensure essential elements of general cleaning were undertaken. Cleaning schedules were in place but were not being used effectively to keep the premises clean and odour free.

People's nutrition and hydration needs were not always being properly managed. The service was committed to a local authority scheme, known as Prosper aimed at promoting new ways of reducing preventable harm from falls, urinary tract infections and pressure ulcers. Although, individual risks to people's health due to incontinence, poor skin integrity and dehydration had been assessed, charts to monitor they were receiving adequate hydration and being repositioned regularly were not always completed properly by staff, which increased the risk of people not receiving the care they needed. We recommended that additional training is provided to ensure staff completed records correctly and to reflect the actual care provided. People's moving and handling risk assessments and care plans indicated the equipment they needed to move, but did not include specific information about the slings to be used to ensure the fit, comfort and safety of the person being hoisted.

The service was providing end of life care to people, however there were no links with the community palliative care team or hospice. The registered manager was not aware of specific guidance with regards to end of life care, such as the National Institute of Clinical Excellence (NICE) quality standard or the Gold Standard Framework (GSF). These provide good practice guidance to ensure people nearing the end of their lives receive the best care. Staff were provided with training to give them the skills and knowledge to meet people's specific needs, including end of life care, however, staff were not always using their learning to provide appropriate care that ensured people were pain free and comfortable at the time of their death.

People and their relatives were complimentary about the attitude and capability of the staff. Staff were kind and had developed good relationships with people using the service. Staff had a good knowledge of what people could do for themselves, how they communicated and where they needed help and encouragement. People were supported to make choices and decided how they spent their day.

There was sufficient staff on duty to keep people safe. A thorough recruitment and selection process was in place, which ensured staff recruited had the right skills and experience and were suitable to work with people who used the service. Staff demonstrated a good awareness of safeguarding procedures and knew who to inform if they witnessed or had an allegation of abuse reported to them. The registered manager was aware of their responsibility to liaise with the local authority where safeguarding concerns were raised and such incidents were managed well.

The registered manager and staff had variable understanding of the requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). People lacking capacity were not consistently supported in line with the requirements of the Mental Capacity Act (MCA) 2005 legislation.

People's needs were assessed on admission to the service and formed the basis of their care plan. However, we found people's care plans were not always person centred, complete or reflective of their current needs. Where people were referred to as having challenging behaviour, their care records did not show how this had been assessed. It was difficult to see how their behaviour was challenging and how this was likely to affect the person or others.

'Sparkle' events were arranged for people to enable them to follow their interests and take part in activities that they still loved to do. A 'come dine with me' experience took place on a regular basis where people had the opportunity to enjoy an evening meal with others from a different service within the organisation. However, there was mixed responses from people regarding activities. Some people told us there was a good choice of activities; whereas other's felt there was little to do during the day. People using the lounge in the Gables took part in stimulating activities, in contrast people sitting in the front lounge sat for prolonged periods of time with little social interaction or engagement from staff.

People, their relatives and staff spoke positively about the registered manager. Staff felt supported by the registered manager. They described them as approachable, very hands on, supportive and demonstrated good leadership, leading by example.

The registered manager and area manager were completing audits of the service on a regular basis, however these were not used effectively to identify where improvements were needed. Infection control audits had not identified the issues of poor cleanliness, in particular in people's rooms. An audit carried out by an independent consultant identified issues with medicines management. The last medicines audit carried out by the registered manager identified the same issues with 'as required' medicines, but no action had been taken to make the required improvements, and we found the same issues at this inspection. The falls log was being reviewed each month; however these were not being used as intended, to identify

themes or trends. At this inspection we identified a pattern of falls between 10pm and 4am, but the falls monitoring did not identify this and therefore no action had been taken to analyse why there was an increase in falls during this time period. Complaints were investigated in full and were responded to in a timely way. However, the outcome and judgements made were not always open and transparent or used to improve the quality of the service.

The registered manager told us staff were encouraged to share innovation and ideas and had embraced the Prosper project with a view to reducing preventable harm from falls. Staff came up with the idea of 'No frame the same' where they helped people to decorate their walking frames to personalise them so they are able to recognise there frame easily and use it. This won a falls prevention award at the Caring UK national awards for innovation.

The registered manager attended regular management meetings with managers from others services owned by the provider to share ideas and best practice. They had developed good working relationships with other agencies such as Hearing Action and attended Prosper community events. However, they had not recognised the importance of partnership working with other agencies, such as hospices or McMillan nurses for people nearing the end of their life.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Systems were in place to assess and respond to risk, but these were not always consistently applied or managed to protect people from harm, or the risk of harm occurring.

Staff understood their responsibilities to raise concerns, record safety incidents, concerns or near misses. They demonstrated a good awareness of safeguarding procedures, how to recognise and report signs of neglect or abuse.

There were enough staff to meet people's needs. Systems for recruiting new staff were carried out safely to ensure potential employees were suitable to work at the service.

People's medicines were not being managed consistently and safely. This is because medicines, including controlled drugs were not always obtained, stored, administered and disposed of appropriately.

Systems in place for the prevention and control of infection did not protect people using the service from the risk of infections. The arrangements in place for the ensuring the premises were clean were not effective.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had good access to training to ensure they have the skills and knowledge to carry out their roles and meet people's needs. Although staff had attended training they did not have a good understanding of supporting people through end of life care, dementia and behaviour described as challenging.

People were supported to have choice and control over their lives and staff supported them in the least restrictive way possible.

People were happy with the meals provided and were provided with enough to eat to maintain a balanced diet. However, where

people were at risk of choking or becoming dehydrated these risks were not being sufficiently monitored or managed, which increased the risk to their health and wellbeing.

People received support to maintain their health and had access to appropriate healthcare services.

With exception of the courtyard garden, the decoration and design of the premises does not support people, particularly those with dementia, to maintain their independence. The décor in parts of the home was looking tired and in need of further maintenance.

The registered manager and staff have variable understanding of the requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). People lacking capacity were not consistently supported in line with the requirements of the Mental Capacity Act (MCA) 2005 legislation.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy was respected, but their dignity was not always maintained.

People and their relatives were complimentary about the attitude of staff. Staff were kind and caring and had developed positive relationships with people using the service.

Staff had a good knowledge of what people could do for themselves, how they communicated and where they needed help and encouragement.

People were supported to make choices and decide how they spent their day.

Is the service responsive?

Inadequate

The service was not consistently responsive.

People's care plans were not always person centred, completed or reflective of their current needs. This placed people at risk of not receiving the care and support they needed.

Complaints were investigated and responded too, however responses to complaints showed there was a tendency to be defensive and minimal acceptance of where things have gone

wrong.

Not all people using the service were provided with the support they needed to experience a comfortable and dignified pain free death. The service did not work in accordance with best practice guidance or with other healthcare professionals to ensure proper systems were in place to provide palliative care. Staff were not knowledgeable about how to support people well at the end of their life.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People, their relatives and staff spoke positively about the registered manager. Staff felt supported by the registered manager.

Although regular audits were taking place to assess the quality of the service these were not being used effectively to identify where improvements were needed. Falls were being reviewed each month; however a trend, such as an increase in falls had not been identified or acted upon to protect people from the risk of harm.

A 'resident / relative, staff and friend committee' of Chalkney House are in the process of being implemented with the intention of giving a voice to all interested parties so that they can be fully involved when making decisions about ways to improve the service.

Staff used creative ways in trying to reduce preventable harm from falls, by introducing 'No frame the same'. People were supported to decorate their walking frames making them identifiable and more accessible to use.

The registered manager had developed good working relationships with other agencies, such as Hearing Action, the GP, social workers and district nurses and attended Prosper community events. However, they had not recognised the importance of partnership working with other agencies, such as hospices or McMillan nurses for people nearing the end of their life.

Chalkney House

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 01 and 03 November 2017 and was unannounced. On the first day of the inspection the team consisted of two inspectors, an inspection manager, a specialist professional advisor in nursing care for older people 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. On this occasion their expertise was in dementia care. The second day of the inspection was completed by two inspectors.

Before the inspection we reviewed information available to us about this service. The registered provider had completed a Provider Information Return (PIR). This is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information provided in the PIR and used this to help inform our inspection. We also reviewed previous inspection reports and the details of complaints, whistleblowing concerns, safeguarding events and statutory notifications sent by the provider. A notification is information about important events which the provider is required to tell us by law, like a death or a serious injury.

We spoke with fifteen people who were able to express their views, but not everyone chose to or were able to communicate effectively or articulately with us. Therefore we used the Short Observational Framework for Inspection (SOFI) which is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with six relatives and two visiting health professionals who were visiting the service during our inspection. We also spoke with five staff, the administrator, registered manager and an area manager for the company.

We looked at nine people's care records, three staff files and reviewed records relating to the management of medicines, complaints, staff training, records in relation to maintenance of the premises and equipment

and how the registered persons monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

Prior to this inspection the registered manager had notified us that there had been an outbreak of sickness within the service. We reviewed the actions they had taken in response to the outbreak and were concerned. This was because the records of people who had sickness or diarrhoea showed that the illnesses started on 17 May 2017 and some people continued to show signs of the illness on 24 May 2017. In response to the outbreak the service had appropriately implemented a deep clean and disinfection programme, however this started on 17 May 2017 and finished on 20 May 2017 whilst people continued to have symptoms passed this date. This meant that the disinfection and cleaning programmes would not have been effective in controlling the outbreak further.

Infection prevention and control policies were in place and the service had copies of the expected best practice guidance. However, these policies were not always implemented to ensure that staff had the appropriate guidance to follow and essential elements of general cleaning were not included in monitoring charts or instructions. For example, we looked at the cleaning schedules and whilst these covered the bedrooms, kitchen and communal areas (night staff are assigned these tasks) there were areas that were missed which were seen on the day of inspection to be unclean. Both medicine storage rooms and the waste disposal areas were not acceptably clean. In contrast, bathrooms were not detailed on the cleaning schedules however all were found to be clean.

There were signs around reminding staff to wash their hands and we observed staff following this appropriately. Infection control training had been delivered to staff by an e-learning package and we observed staff using personal protective equipment at all times when this was needed. They used colour coding for equipment such as mops, appropriately to ensure they minimised the risk of cross infection. However, three of the bedrooms we visited had a powerful and overwhelming odour of urine. On further examination it appeared that floors, beds and bedding in these rooms were not being cleaned to an acceptable standard. For one person we saw that their care plan identified the risk of incontinence, however there was no instruction within the care plan to mitigate this risk with increased cleaning within this room. We saw that following a complaint from their family member the registered manager had implemented three daily disinfecting of the floor within this room. We saw the mopping schedule in the room and this showed that the room was being mopped once a day not three times. There was no record to reflect the room was being mopped at all over the weekend. The impact of this meant that the odour within the room was powerful and needed to be addressed. We observed the room following the domestic cleaning and saw that the floor had been mopped and bed linen changed. However the duvet, which was heavily stained with an extreme smell of urine, was just replaced with a fresh duvet cover. This did not ensure the smell within the person's bed was improved. The cleaning schedule identified that this person's bedding was not changed daily and on some weeks it was not changed for four days. The washing of the person's duvet was not listed on the schedule and was not seen to be washed regularly.

This was a breach of regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Prior to the inspection we received information of concern about people not receiving their prescribed medicines. At this inspection we found that medicines were not being managed consistently and safely by staff. This was because medicines, including controlled drugs were not always being obtained, stored, administered and disposed of appropriately. Controlled drugs are medicines that have legal controls because they may be misused, obtained illegally or cause harm. The storage of controlled drugs (CD's) did not conform to the British Standard BS2881:1989 which describes what providers must do to comply with the safe practices. This standard does not require the CD cupboard to be within another cupboard. However, the service were using a lockable CD cupboard within a locked cupboard, but the inside CD cupboard did not have a lock and other items such as a lighter and insulin syringes were being stored in the main cupboard. This was not safe practice as other staff had access to the cupboard and the unlocked CD cupboard within. Therefore the controlled drugs were not stored safely and securely. The cupboard was also dirty and dusty.

Routine medicines were stored in locked trolleys and secured to the wall in medicines storage rooms when not in use. These rooms also contained fridges used to store medicines. Log books for monitoring the daily temperature of the fridge and medicines room were being kept. However, the log books were not completed appropriately, as they did not specify which log book was for which fridge. The dates when the temperatures were taken were not always recorded. Therefore it was not possible to know if the fridge and room temperatures were being maintained to ensure people's medicines remained effective.

Where people had been prescribed medicines on an 'as required' basis, such as Lorazepam, protocols were in place to guide staff on when this should be administered. However, we found people were being given these medicines on a regular basis. For example, one person had been receiving Lorazepam twice daily, in the morning and in the evening for more than a month. Although, concerns had been raised by staff to the GP by a fax on 22 August 2017 there had been no response from the GP. Staff had not escalated the problem to ensure a quick and effective resolution. At the time of this inspection there had been no review of this person's Lorazepam and they continued to receive this on a regular basis.

Unused medicines were placed in a plastic container without being labelled. Most if not all the medicines to be disposed of were loosely placed in the box instead of individual labelled plastic bags, designed for that purpose. The plastic bags used were not labelled and failed attempts had been made to write on the plastic bags. Retrieving the medicines proved extremely difficult because they were amongst other items such as plastic bags, medicine cups, tablet crushers and cutters. A member of staff administering the medicines told us, "We ran out of labels and have not received the order". These unused medicines had been accumulating for the past three weeks without any action being taken. Each unused drug before being returned to the pharmacy and disposed of needed to be recorded with the name of drug, number of tablets and strength. This inappropriate and unsafe method of storing unused medicines made it practically impossible to identify the medicines and make an accurate record of medicines to be returned.

This was a breach of regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014□

Irrespective of the improvements needed as described above a random sampling of people's routine medicines, against their records confirmed they were receiving their medicines as prescribed by their GP. Any medicines not taken by people, for example where they had refused, or were not available to take their medicine had been recorded on the back of the MARS. Body maps were used to indicate the site where topical applications were to be applied. The records showed that staff alternated the site of pain patches and recorded appropriately the date when these were applied and removed.

Individual risks to people were assessed, but management plans to mitigate these risks were not consistently followed by staff or amended where people's needs had changed. For example, one person had been identified as at risk of developing pressure ulcers and to help prevent these occurring required repositioning on a two hourly basis. Their health charts showed that staff did not always carry out these instructions. On 31 October 2017 between 13:40 until 24:00 hours they were recorded as being positioned on their back. On 01 November 2017 between 01:00 and 07:00 they were recorded as remaining on their back. This meant that over a 17 hour period the person's position had not changed. Although the person did not have a current pressure wound the lack of repositioning put them at greater risk of their skin breaking down. In contrast, another person's care records reflected they were at high risk of developing pressure ulcers and was being nursed in bed. Their care plan stated the need for regular hydration, continence management and to reposition frequently. Their health charts indicated that the prescribed care had been given. We visited this person during the inspection and found they had no sign of dehydration, pressure ulcers or pain, reflecting they were receiving adequate care to prevent the risk of developing pressure ulcers.

We recommend that additional training is provided to ensure staff complete records correctly to reflect the actual care provided.

Another person's 'service user profile' described them as being fully mobile with no aids. However, staff had updated their waterlow score (This is tool used to assess the risk of a person developing a pressure ulcer) on a monthly basis and on 27 September 2017 the score had increased because the person was recorded as now being chair bound. However, incident and accident reports reflected they had had two falls, one in September and one in November 2017. The person's manual handling risk assessment had last been reviewed on 23 August 2017 and stated 'no change at present.' We spoke with staff to clarify what level of assistance the person required with transfers, they told us that the person was sometimes independent but sometimes used a stand aid to transfer. This was not reflected in their care plan and no action had been taken to prevent further falls. Their Personal Emergency Evacuation Plan (PEEP) was also not reflective of their current need, it stated that they were able to mobilise independently with a stick and that they required the assistance of one member of staff to give simple instructions. Each person had a framed photograph outside their door to help them identify their room. The frames were colour coded to reflect the level of risk identified in their PEEP and were a quick guide for staff if they needed to evacuate people quickly. The incorrect information in the person's PEEP meant the risk was not properly assessed and in the event of an emergency the existing information (and colour coded frame) would not guide staff to provide the right level of support to keep the person safe.

People's moving and handling risk assessments indicated the equipment they needed to move, including the number of staff required to support the person to transfer and the type of hoist to be used, for example hoist or a stand aid. However, there was no record of what size sling they had been assessed as needing to ensure this was suitable for their height and weight. Neither did they specify what colour loop was required to be used on the sling to ensure the fit, comfort and safety of the person being hoisted.

This was a breach of regulation 12 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The environment was regularly monitored to ensure people were kept safe from harm. A business contingency plan was in place detailing who to contact in an emergency such as a lift breakdown, gas supply failure or if residents needed to be evacuated where they would be relocated to. Staff knew who to contact if such an emergency arose. Maintenance records showed fire alarms were regularly checked to ensure they were in good working order and the gas safety certificate was up to date. Water taps were fitted with thermostatic mixing valves and the temperature of the hot water was regularly checked to ensure that

it was within a safe range for people to use. Records showed that the hoisting equipment was regularly serviced and personal electrical appliance (PAT) testing had been carried out to ensure that electrical equipment was in safe working order. However, the last fire service inspection of the service had taken place in 2014 and had identified a number of areas requiring improvement. There was no evidence to show that these improvements had been made.

Irrespective of the concerns raised above, people told us they felt safe living at Chalkney House. Comments included, "Yes, I am safe, they look after me" and "Safe as anywhere else, got a buzzer, staff all okay as far as I am concerned." One person told us, "Mostly they [staff] are nice, I can stick up for myself and I would shout back if I needed to, but they are all nice here." Another person said, "There are staff on all night and got a bell on the wall and they come right away." One relative told us, "My [Person] is safe, they say they try to get out and cannot so I know [Person] is safe and not getting out."

Policies in relation to safeguarding and whistleblowing reflected local procedures and relevant contact information. Additionally, posters were clearly displayed on notice boards throughout the service about safeguarding and how to whistle blow. These provided clear guidance to staff on how to report concerns within and outside the organisation. Staff told us they had received updated safeguarding training and were aware of different forms of abuse. For example, one member of staff told us how they ensured a person's valuable items were checked, logged using photographs and stored in the safe to protect their property when they had moved into the service. Staff were aware of their responsibility to report concerns, record safety incidents and near misses and to report them. They demonstrated a good awareness of procedures to follow and knew who to inform if they witnessed or had an allegation of abuse reported to them. The registered manager was aware of their responsibility to liaise with the local authority where safeguarding concerns had been raised and such incidents had been managed well.

People told us there was always staff available if they wanted help. One person told us, "Don't wait long as a rule, they are pretty good." Another person commented, "Never had to call staff at night, got a bell push and someone will come, there are always people on, they are friendly and will sit down and chat with you." A third person told us, "Bell, they are always quick." They demonstrated this to us by pressing their call bell and staff responded within a minute. One relative commented, "Care is good, nothing is too much trouble, they are friendly but not over the top, there seems to be enough staff". Staff confirmed there was sufficient staff available to meet people's needs. We observed staff responded promptly to peoples call bells, reaction time was between one to two minutes. People and their relatives told us this was normal. The registered manager told us they used a national care forum dependency tool to calculate staffing levels and this was reviewed weekly. If people's needs changed, staffing numbers were adjusted accordingly. The registered manager told us current staffing levels were seven staff across day time hours, with two staff at night. These levels had stayed the same even though they were not at full occupancy. They told us they currently had three staff vacancies, but staff worked flexibly to cover shifts and staff absences. Agency staff were used when needed, but not recently.

Recruitment processes were in place and well documented. We reviewed the recruitment process in respect of the last three members of staff to be appointed and saw that relevant checks were in place to ensure that the staff members were safe to work with vulnerable adults. For one member of staff there was a potential risk highlighted by one of their referees during the recruitment process which did not appear to have been considered. However, the registered manager told us that this was thoroughly explored during the interview process and they concluded that there was no risk to people using the service.

Requires Improvement

Is the service effective?

Our findings

The PIR states nutrition and hydration are well managed in the home. However, we found risks in relation to people's nutrition and hydration were not always being properly managed. For example, one person had been assessed on admission to the service in August 2017 as requiring a soft diet and required full support with eating. The 'How to support me' plan stated they had a normal diet and drinks well, but they were admitted to hospital due to poor oral intake and choking when swallowing in September 2017. Whilst in hospital they were treated for dehydration. Following discharge back to the service, their care plan had not been reviewed and still referred to a normal diet. However, staff told us they required a soft diet. There was no information in the persons care plan to reflect if there had been involvement from the Speech and Language Team (SALT) or who recommended a soft diet, and no information about choking risks. Their nutrition care plan was being reviewed monthly, with 'no change' recorded, despite being admitted to hospital and referred to the GP in September 2017 for not eating or drinking.

Analysis of the nine people's charts from 01 to 10 October 2017 showed the amount of fluid consumed at the end of each shift, including the night, were not added up and therefore there was no running total. The continence nurse visiting the service on the day of our inspection advised people's fluid intake is calculated according to the persons weight. None of the charts identified the person's weight or the target input of fluids required to keep the person hydrated. For example, one person's fluid intake was recorded as between 200 and 500mls of fluid over a 24 hour period. Their care plan identified they had difficulty taking in fluid. However, there was nothing recorded in their care plan to specify how often the person should be offered drinks. We visited this person during the inspection at 15:00 hours. They had a drink by their bedside but could not reach it. When we checked them again at 16:45 hours the level of fluid in the beaker remained the same and the chart reflected they had not been offered any fluids for nearly two hours. When we compared the health charts for the nine people for the same period, we found the same member of staff had signed the charts at 20:00 hrs, 22:00hrs, 24:00hrs, 02:00hrs, 04:00hrs, 06:00hrs and 07:00 hrs simultaneously to say they had given all nine people their fluids, provided personal care and repositioned them. This would be impossible to achieve which meant the charts were being completed retrospectively and not a true reflection of the actual care provided.

People told us they enjoyed the food and we saw that they were offered a choice of meals and snacks at regular intervals throughout the day. Comments included, "Food is quite nice and I enjoy my lunches" and "Food is good, nice sweet, like the new potatoes and greens, but not a lover of fruit" and "Food is okay, I like the cooked breakfasts." We observed the lunch time meal in the dining room and although some people were chatting at tables this was not a sociable occasion for all. One person sitting in a wheelchair was placed on a table on their own with their back to the room. At one point staff were laughing and joking with another person about a hat that they were wearing, the person with their back to the room said, "I don't know what you're talking about because I can't see." This person initially ate very little of their main meal. A member of staff tried to encourage them to eat, but rather than spending time with them they were in and out of the dining room and did not provide the support they needed. Another member of staff provided them with assistance to eat their dessert when they had finished assisting someone else. The persons care plan stated that they required support when eating and drinking, this was not initially provided with their

main meal. Their care plan stated, "[Person] is low weight and has a small appetite. They require staff verbally prompting and assisting with all foods and fluids.

The PIR states people are involved as best as possible in the development of the menus and that the 'meals that go down the best are offered more frequently' People told us there was always two choices of main meals and that there was a good choice of deserts. People were shown plated options to enable them to make a choice, but not everyone had or was offered a drink before lunch began. There was no finger food available, one person was observed eating spaghetti bolognaise with their fingers. However, people told us they had enjoyed their meal. One person said to the person sitting next to them, "That was nice wasn't it." Another person commented, "Very nice, lovely, I managed it all."

This was a breach of regulation 14 (4) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The Mental Capacity Act (MCA) 2005 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. In the nine peoples care records reviewed we found people lacking capacity were not consistently supported in line with current legislation. For example, records showed that people who had been assessed as lacking capacity had been given an influenza vaccination. There was no information to demonstrate that consultation with their relatives or GP had taken place to assess if this was appropriate and in their best interests.

Assessments of people's ability to make some decisions had been assessed; however the level of detail varied and needed to be more specific about the decision being made. For example, MCA assessments for two people identified they lacked capacity to make decisions about their personal care due to their dementia and were unaware of the need to maintain their hygiene, however there were no further assessment of their ability to make other specific decisions, for example, what they wanted to eat and drink. Additionally, one person spoken with during the inspection clearly struggled with decision making, but had no MCA assessments in place at all. Where decisions were being made on people's behalf their family representatives and / or professionals should be involved in making decisions that are in the best interests of the person. Although some best interest decisions forms were being completed these had been signed by the registered manager. They had recorded that they had discussed the issues with the people's representatives however there were no signatures of next of kin to confirm this. Where consent to treatment forms had been signed by family members; there was no clear indication as to whether the family member was the persons Lasting Power of Attorney (LPA). A LPA is a person that has been appointed by the person to help them make decisions or to make decisions on their behalf.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). The registered manager showed us a DoLS tracker which reflected applications had been made to the local authority for people subjected to restrictions to their freedom for their own safety, however we found only one out of the 37 requests had been authorised. The registered manager showed us an email they had sent to the local authority to chase a response to these applications.

We found people were not always receiving effective care and support to maintain their health and wellbeing. Although people's needs had been assessed on admission to the service, some care plans were incomplete and where their needs had changed these had not been updated to reflect their current needs. For example, one person's records showed they had been diagnosed with dementia, arterial fibrillation, hypertension, frequent urinary tract infections (UTI's) and was independently mobile. Their mobility and falls assessments made reference to a history of falls. The person had been prescribed a range of medications for their pre-existing conditions, but the side effects of dizziness and insomnia had not been factored in when completing their moving and handling assessment on 24 August 2017. A review of their mental health behaviour on 10 October 2017 identified they were slightly more confused this month and were 'continually wandering'; however no changes were made to their risk assessment. They fell on 15 October 2017 and were admitted to hospital where they had an operation to repair a fractured hip. A review of the general health section in their care plan on 15 October 2017 had recorded the fall and that they would need two staff to support them when they returned due to the fracture hip. They returned to the service on 21 October 2017 with a booklet of exercises recommended by physiotherapist and occupational therapist to strengthen the muscles around their hip joint to help recovery and decrease the risk of hip dislocation post-surgery. When we inspected on the 01 November 2017 their care plan had not been updated to reflect this information. There was no information recorded to reflect the exercises were being completed.

We visited this person in their room where we found an overwhelming odour of urine. Additionally, they were wearing nothing on their feet and we noted their feet were in very poor condition. Their toe nails were thick yellow and very long. Their feet in particular in-between their toes were very dirty. The registered manager told us they walked bare foot; however this was not reflected in any of their assessments. Their foot care assessment was blank, and there was no other information about managing this aspect of their care, other than a statement, 'I wish to see the chiropodist every 4-6 weeks'. Records showed this was not regularly happening. The registered manager told us they missed a recent visit from the chiropodist as they were in hospital. They also told us the person frequently refused care and became physically and verbally aggressive when staff tried to help them. They described them as strong minded and difficult to persuade. A risk assessment had been completed for managing aggressive behaviour, and they had been assessed as medium risk. There was no bench mark to reflect how they had been assessed as medium risk, and the only guide for staff was to 'ascertain what was wrong, offer reassurance and explain they may cause upset to others'. There had been no referral to the mental health team to discuss their behaviour and tendency to self-neglect. Neither was a record of the frequency of the behaviour recorded to ascertain potential triggers or what additional support they may need.

Staff told us they received a range of training, including topics to meet the specific needs of people who used the service, such as Parkinson's, dementia, nutrition and end of life care. Staff told us the training and support they received had provided them with knowledge and skills to meet people's needs. For example one member of staff told us where they had not been sure how to use slide sheets to reposition people in bed, the registered manager had arranged a demonstration session for staff. Although, staff told us they had received training we found they were not always putting this learning into practice, for example we found they had limited understanding in supporting people with dementia, challenging behaviour and end of life care.

When new staff joined the service they told us they received an induction. Two staff files reviewed showed they had limited experience prior to starting at Chalkney House; however information in their files showed they had completed a comprehensive induction consisting of both classroom training and computer based learning, including the Care Certificate. The Care Certificate was developed jointly by the Skills for Care, Health Education England and Skills for Health. It applies across health and social care and sets a minimum standard that should be covered as part of induction training of new care workers. We also saw that staff's

competency was being assessed throughout the probationary period to ensure learning was understood and being applied. Staff told us, as part of their induction they had spent time shadowing more experienced staff for five days over a two week period so that they could learn about people's needs and how best to support them.

People told us and records confirmed they had access to a range of healthcare services, such as the dietician, SALT, district nurse, continence nurse and the community mental health team. One person told us, "Staff are good, two staff took me to the hospital, one of them waited with me and then brought me back." One relative commented, "[Person] had a spell of not eating and was losing weight and they were referred to the GP. We are told what we need to know."

Chalkney House is one building which has been extended over a period of time. Although originally, there was a self-contained specialist dementia care unit, the registered manager told us there is no specific unit dedicated for dementia care, as the majority of people using the service have dementia and "seem to get along and on the whole look out for one another." One relative commented, "We like it here, it's friendly, clean and [Person] has freedom to walk around and go outside into the garden where it is safe. We feel comfortable with them being here." Areas of the building referred to as the main house, cottages, extension, terrace and gables were all linked via corridors; however there was minimal signage around the premises to guide people, particularly those with memory loss. Outside the room of each person there were photographs of the person's family, their loved ones, and their own pictures. These were useful in helping people remember where their rooms were. However, doors to people's rooms, bathrooms and toilets were all white, introducing different coloured doors would help people distinguish between bathrooms and toilets.

The décor in parts of the home, including people's rooms were looking tired and needed redecorating, particularly in the older part of the building. We also found that some toilets did not have door looks for privacy. The registered manager told us the provider had a maintenance plan in place, but this was not available for us to review. The courtyard garden had been nicely landscaped and provided a safe and secure environment for people. Bunting and a range of nice seating gave the garden an inviting appeal. They told us there were plans to develop an indoor sensory garden to enhance activities for people who are unable to access the garden or use if the weather was bad.

Requires Improvement

Is the service caring?

Our findings

Prior to our inspection we received information of concern about people receiving poor care, in particular a lack of hygiene. Issues were raised about people being left in soiled continence pads and clothing, resulting in a strong smell of urine, or being in the same clothes for days. At this inspection we found staff were not consistently providing care and support to people in a way that ensured their dignity was maintained. For example, people's incontinence was not being well managed and staff had not followed cleaning schedules, which resulted in an overpowering smell of urine of those people's bedding and in their rooms. Additionally, whilst staff told us they were aware of the importance of ensuring peoples dignity was respected at all times, we observed a lack of empathy and understanding of the needs of a person reaching the end of their life.

Concerns had also previously been raised with us about people's hearing aids going missing and wearing other people's glasses. One relative told us they had on occasion found their relative inappropriately dressed, for example, "One day [Person] had pyjama bottoms and shirt and jumper on from previous day; however that was a one off. Another day [Person] had no knickers and no bra on, just a shirt and jumper, but they may have taken them off, they are dressed fine today." Another relative told us, "Wet pads happen sometimes, but it is pretty good at the moment." Overall, we found people were clean, dressed in appropriate clothing, their hair was tidy, they were wearing their hearing aids and their glasses were clean.

One person told us, "Staff are very nice and helpful, [staff member] is my keyworker and they offered to give me a bath. I said no as I only wanted ladies and they respected this." Where people had chosen to eat their meal in their rooms, we observed staff taking their meal to them on trays. Staff knocked on their doors before entering and engaged well with people making sure they had what they needed to enjoy their meal.

The 15 people spoken with told us they were happy with the care and support they received and were positive about the staff. One person told us, "I am looked after and the staff are alright." Another person commented, "I have a pad sometimes, which is alright, I am looked after. Other comments included, "Usually I shower, but staff know I like an all over wash too" and "Staff are very good, they do want you want them to do and "I like it here, I am new, everyone is friendly and I like the company. I feel a lot more settled." One relative, commented, "Care is good, nothing is too much trouble, they are friendly but not over the top". Another relative told us, "[Person] has settled, at home they were struggling to be up in the mornings and may well have refused here to get up, but they are up today. They are more accepting of help from staff and have developed a good relationship with two of the staff."

Staff had a good knowledge of what people could do for themselves, how they communicated and where they needed help and encouragement. For example, where a person was able to eat their meal independently, a member of staff noted they were sleepy after having their hair done and was not eating their meal. They provided encouragement to the person, commenting "[Person] I've got you some lunch, can you sit up a bit for me." The member of staff helped them to start eating their meal, until they took hold of the spoon and managed the remainder for themselves. The member of staff commented, "[Person] can do it themselves and does get there in the end."

We saw positive interactions between staff and the people they supported. They were friendly and showed concern for people's wellbeing. For example, the registered manager noted a person had not eaten much of their meal, they asked them if they wanted something else to eat. The person started to cry and the registered manager knelt down, taking the persons hand and comforted them and provided reassurance. We also saw a member of staff supporting a person being transferred from an armchair into their wheelchair. This was nicely done with the member of staff kneeling in front of them making eye contact explaining what they were doing and offered reassurance when the showed discomfort. Another member of staff spoke with a person commenting that they needed a haircut and asked them if they wanted to see the hairdresser. They returned within a few minutes, commenting, "You're all booked in and they will come and get you." They noticed the person looked tired and asked if them if they were in pain, and provided kindness and comfort reassuring the person they would get them some pain relief, when the person said they were.

People described the staff as "Helpful and kind." One person told us, "When I came I only had my handbag, now I have got clothes and shoes which have all been donated, I have got my phone in my bag but the charger is still at my house so one of the carers has lent me theirs, I think it is wonderful here and they [staff] have helped me out allot." Another person commented, "Everyone is friendly, and I have got a friend here. They [staff] are friendly and will sit down and chat with you." A third person told us, "Staff are nice, there are no staff you can grumble about, they are chatty and amenable." We saw one person became upset about the loss of a family member. A member of staff comforted them, commenting "You have some good memories about your [family member's name] and they are really important."

People told us they were supported to make choices and decide how they spent their day. One person told us, "I like it here because I can get up late. Then I go down to lunch and stay down till the evening." One person sitting at the back of the dining room was not eating, a member of staff commented that they "Liked to nap in the mornings and liked their lunch later than the others." This was respected and we observed staff brought them their lunch when everyone else had finished.

The PIR stated all decisions about people's care were made in their best interests starting with the care planning process and wherever possible people and their family were involved in the process.
The registered manager told us families were invited to read and review people's support plans and this was confirmed in discussion with relatives spoken with.

Although staff had received training in MCA they had a varied understanding of these pieces of legislation, but were able to tell us how they supported people to make decisions and understood when families needed to be involved. For example, one member of staff told us a person who used to be a vegetarian had started requesting meat as an option at meal times. They arranged a meeting with the person and their family to talk through their choice to eat meat. The family agreed that it was their decision if they chose to eat meat. Staff described how they helped people who might find it difficult to make decisions and told us they always asked them for their consent before providing care and support. For example, one member of staff told us when they helped people to dress they "encouraged them to choose their own clothes".

Staff provided encouragement to people when they needed it and supported them to retain their independence wherever possible. One person told us, "I like to tidy my own room, but I get the cleaner to do the floor." Another person told us, "If I have a problem I know I can go to [staff member] and they try and solve it for me and if I get upset they told me to write it down and we read it, rip it up and solve it".

Inadequate

Is the service responsive?

Our findings

Prior to this inspection we received concerns from three sets of relatives about the standard of end of life care provided to their family member. We spoke with the registered manager about how people were supported at the end of their life to have a comfortable and dignified pain free death. Despite providing end of life care for people they had had failed to develop any links with the community palliative care team or hospice. The registered manager was not aware of who their local hospice was and did not know about specific guidance with regards to end of life care, such as the National Institute of Clinical Excellence (NICE) quality standard. These standards provide guidance to providers regarding the care of adults who are dying, during the last two to three days of life. Neither were they familiar with the Gold Standard Framework (GSF).This is a model that enables good practice to be available to all people nearing the end of their lives to ensure they receive the best care. The GSF offers training to care homes to train staff so that they have the skills to provide the highest possible standard of care for people who may be at the end of their life. The aim is to promote joined up care so that everyone involved in the person's care knows about their wishes and is best prepared to ensure that they are fulfilled. During the inspection the registered manager made enquiries to find out who their local hospice was and had arranged to meet with them to discuss additional training and support.

We were informed a person using the service was at the end of their life during the first day of the inspection. When we returned two days later we were informed the person had not passed away. The registered manager told us all food, fluids and medicines had been stopped for this person for the previous two weeks as they were on end of life. However, there was no records in the persons care plan to reflect who made this decision, or if the family were involved. The registered manager told us the GP had made the decision, but this was not recorded.

Staff told us they had received in house training for managing people's end of life care but we did not observe this being effectively put into practice. For example, we found one person on end of life lying in bed alone in their room, with no music or human contact to provide comfort and reassurance. We reviewed this persons care records and found a palliative care plan in place which had some elements of end of life care, such as making the person comfortable, providing appropriate personal care, regular changes of position and giving fluid as tolerated by the person, accompanied by regular mouth wash. When we asked to see the person's charts to check they were receiving fluids, being turned etc. none were available, therefore we could not see what care was being given. Although, the person did not look like they were in pain or distress their care plan stated they were a diet controlled diabetic. Their food and fluids had been stopped and there was no information to reflect how their diabetes was being managed. Staff told us the person was receiving analgesia (pain relief), however there was information available, such as pain charts to demonstrate how staff were assessing if they were in pain and needing pain relief. There was no clear plan or strategy about how staff were to meet the wishes of the person 'to have a comfortable and pain free death'.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

In contrast to the concerns raised above one relative told us they had a positive experience when their [Person] had passed away at the service. They commented, "Both my parents resided here. It is very good and friendly, unfortunately one of my parents passed away in June, this year. The manager talked with me about managing their end of life care beforehand and explained what was going on and what to expect. They told us we could stay, and provided a mattress so we could sleep in their room; we stayed for three or four days and they [staff] fed us. We were made to feel absolutely comfortable. The staff managed a really difficult situation well, it was lovely and we couldn't have asked for more. The manager was really good with me, and so was the activities coordinator. They sat with my [Person] for a long time to give us a rest and get some air. It was our first family bereavement and they supported us, [Person] was comfortable with their syringe driver, they [staff] were fantastic."

DNAR forms in people's care plans had been completed appropriately. A DNAR form is a document issued and signed by a doctor or medical professional authorised to do so, which tells the medical team not to attempt cardiopulmonary resuscitation (CPR). These had been signed by the person in the presence, where able to do so, and or their relative and GP. However, we found these had been placed right at the back of their care plan folders instead of the front and therefore were not immediately accessible in the event of an emergency situation.

Prior to the inspection we had been made aware of a three complaints which had been raised with the service. Relatives had told us that they were not always happy with the response. We reviewed the complaints received along with the evidence of any investigation alongside what we had seen during the inspection. People knew how to complain and there was a complaints procedure available and feedback forms were seen at the service during the day. Complaints were investigated in full and were looked at in a timely way, however we were concerned about the outcome of the complaints which showed a culture of minimal acceptance when things had gone wrong and the responses were defensive in approach. For example, two complaints had been made in reference to the cleanliness of a person's room. The complaint was considered unfounded and the investigation focussed on the cleaning schedule as evidence that the room was clean. We found the room to still have an overwhelming smell of urine. Whilst the registered manager had implemented further cleaning in the room, this had not been maintained which showed there had been little learning applied from the complaint and improvements for the person had not been maintained. Another complaint from a member of staff had also raised the concern around the smell within the home. The response to this complaint was that it had been a false allegation, however there were elements within this complaint that we found to be accurate. Whilst people were making complaints and these were being investigated, the outcome and judgements made were not always open and transparent, therefore we were not confident that people would continue to raise concerns or complaints and be sure that they would be used to improve the quality of care provided.

This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014□

People's care plans were not always person centred or reflective of their current needs. For example one person's care records referred to them being sectioned under the Mental Health Act 1983 (MHA), and within the care plan there was reference to them being detained under the MHA. However, when we spoke with the registered manager they confirmed the person had never been sectioned whilst living in the service and was not detained. Their care plan was therefore not accurate.

Where people were referred to as having challenging behaviour, their care records did not show how they had been assessed as high, medium or low, therefore it was difficult to assess the level of support they needed. Additionally, from the description provided it was difficult to understand how their behaviour was

challenging and how this was likely to affect the person or others. For example, in one person's care plan their behaviour was described as medium risk because they, 'can be a little waspy', and '[Person] does not understand that this can impact on those around them'. In order to determine the level of support this person needed to manage this behaviour a description of what 'waspy' meant was needed, for example, shouting, making gestures verbal or physical aggression if there personal space was invaded. Also to determine the rating the frequency and severity of their behaviour needed to be monitored to reflect the possible causes or consequences of their behaviour. No records were being kept. Their risk assessment was first written on the 21 July 2017 and had not been reviewed since; therefore it was unclear how they had been assessed as medium risk. Neither was it clear why the person had been referred to the community mental health team.

There was a mixed response from people regarding activities. Some people found that there was a good choice of organised activities. One person told us, "I join in what is going on, such as cards and I like colouring." The activities coordinator told us, one person had helped them clear the garden of the tomatoes and runner beans, all of which they ate. However, other people told us that there was little to do during the day. Comments included, "Not really enough to do, they have the telly on morning to night" and "More exercise sessions would be a good idea, outings would be nice" and "I like the card games, but there is not enough to do, I would like to go outside, go on outings like a football match." Some outings had been arranged. For example, a group of people had gone to the local cinema. 'Sparkle' events were arranged for people to follow their interests and take part in activities that they still loved to do. The registered manager gave an example where staff had arranged an aeroplane trip at Stanstead airport for a person who used to be a pilot, however the person declined on the day and their decision was respected. Another person told us that a member of staff had contacted West Ham Football club telling them they were a fan. They told us, "I am unable to attend in person as I am confined to bed, but the football club sent me a placemat with my name on, socks and a signed scarf, I was over the moon." A 'come dine with me' experience took place on a regular basis where people had the opportunity to go to a different service within the organisation for an evening meal. We saw people involved in preparing food for the 'come dine with me' being held at Chalkney House that evening.

The service has four lounges, including a quite lounge and a reminiscence room. The lounge in the Gables had a range of activities throughout the day; including jigsaws, card games and preparing food for 'come dine with me'. There was a nice atmosphere in this lounge; however in contrast there was minimal engagement with people sitting in the front lounge. We saw people sat in front of the television for prolonged periods of time with little social interaction or engagement from staff. Other than a few people having their nails painted there were no activities, newspapers, books or games available. Additionally, staff constantly walked through the quiet area to get people's rooms. One person told us, "There is not always staff in here [quiet area], they [staff] walk through a lot to go to the bedrooms down there." The reminiscence room had a range of items that provided stimulation for people with dementia, however this room was away from the main part of the building at the end of a corridor and only one person was seen using it during the inspection. A member of staff told us, "Residents do not like that room".

One activities coordinator told us, they encouraged people from the community to come in to provide entertainment, for example they were trying to find someone who could visit to play chess with a person with this particular interest. They had placed an advert in a local paper for entertainers and now had ukulele players who visited two or three times a year, regular singers, an organist playing hymns and Irish dancing." This was confirmed in discussion with a relative who told us, "Staff tell me [Person] gets up and dances at the music evenings."

Requires Improvement

Is the service well-led?

Our findings

The registered manager and area manager were completing audits of the service on a regular basis, however these were not used effectively to identify where improvements were needed. For example, infection control audits were carried out on a monthly basis but had not identified the issues of poor cleaning in people's rooms or the missed cleaning of some areas of the home. Where issues were identified within the infection control audits, for example on 20 September 2017 it was identified that the commodes were not clean, there was no action attached to the audit to show that this had been addressed. In other areas the audit paperwork could not be seen as an accurate representation of the situation, for example several of the audits identified that a blood spill kit was required, however audits in between confirm that this was in place. There was no evidence seen that the blood spill kit was in place at the time of the inspection.

An audit of the service carried out by an independent consultant on 15 June 2017 had identified issues with medicines management. The last medicine audit on the 31 October 2017 had identified the same issues regarding medicines prescribed on an 'as required' basis, but no action had been taken to make the required improvements, and we found the same issues at this inspection. Neither had the audit on 31 October 2017 identified concerns about the storage of the controlled drugs, inappropriate disposal of the medicine, the untidiness and uncleanliness of the medicine rooms, and poor recording of room and fridge temperatures.

The PIR stated, 'accidents and incidents in the home are analysed with a view to learning'. The falls log contained good practice guidance which stated 'the form had been designed to show when falls occur to enable us to determine if there is a particular pattern over a period when falls tend to occur more often'. The falls log was being reviewed each month, however these were not being used as intended, for example from January to October 2017 there was a pattern of falls between 10pm and 4am, however the falls monitoring had not identified this and therefore no action had been taken to analyse why there was an increase in falls during this time period.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014□

People, their relatives and staff spoke positively about the registered manager. All said their door was always open and that they could speak with them at any time. One person told us, "The manager is usually in their office and I can go and see her; she is friendly." A relative commented, we feel able to talk to the manager and staff." One member of staff commented, "The registered manager is a massive support to me." Another told us, "They [registered manager] is here every day, even weekends, they are very involved checking everyone is okay, they care a lot."

Staff told us the registered manager was approachable, very hands on and supportive. They felt she demonstrated good leadership and set an example of how care should be provided. However, they did not feel there was the same level of support and open communication with the provider. Staff told us whilst

concerns were raised upwards to the provider by the registered manager, they did not always get a response. These concerns were feedback in the staff survey. The registered manager told us staff had been very forthright in their comments and an action plan to address concerns raised was in place. For example, staff had commented on how they would like to be kept more informed of changes in the service and what was happening and that despite regular staff meetings communication could be improved. As a result a communication book and staff newsletter had been introduced.

The registered manger told us they worked on the floor alongside staff whenever possible so that they could monitor the day to day culture in the service. They told us, "Having a settled staff team is one my greatest achievements, as without united and happy staff this can really change the feeling of a home." They told us they encouraged all staff to form on-going relationships with people using the service and commented, "When staff are genuinely invested in those they care about it is evident within the home. I don't think that you can look after people without investing in them emotionally." The provider's statement of purpose contained the aims and objectives of the service. These were to ensure people's rights to independence, privacy, dignity, fulfilment and the right to make informed choices were respected. Staff were aware of these values, but were not always treating people with dignity and respect. Staff described Chalkney House as a 'happy home', because there was good leadership and a strong well established staff team, 'like a family'.

The registered manager told us staff were encouraged to share innovation and ideas and had embraced the Prosper project. This programme is a Local Authority scheme aimed at promoting new ways of reducing preventable harm from falls, urinary tract infections and pressure ulcers.
Staff had come up with the idea of 'No frame the same' which had had won a falls prevention award at the Caring UK national awards for innovation. Staff had helped people to decorate their walking frames to personalise them in the hope they would recognise there frame easily and use it. The registered manager told us this had worked particularly well with people who had dementia and had reduced falls dramatically within the service. They told us this idea had been adopted by other care homes across the country and several hospitals.

A member of staff had been appointed as a Prosper champion. Champions are staff that have shown a specific interest in particular areas. They are essential in bringing best practice in to the service, by sharing their learning, acting as a role model for other staff and supporting them to ensure people receive good care and where required treatment. The registered manager told us they were planning to develop further champion roles within the home to drive improvement. These roles will cover areas such as dignity, infection control and diet and nutrition. They told us each champion will attend regular meetings with other care homes to develop ideas and share best practice.

Staff told us they received regular supervision and annual appraisal regarding their performance. Supervision is a formal meeting where staff can discuss their performance, training needs and any concerns they may have with a more senior member of staff. Staff told us they felt well supported by the registered manager and their colleagues. One member of staff said, "I have been here two months, I was welcomed like a family member, staff are really supportive and the manager has been a massive support." Staff told us and records showed that regular staff meetings were taking place. The minutes showed areas of concern were addressed, new policies and procedures discussed, ideas encouraged and good practice shared, for example what had worked well and where further improvements were needed. The minutes of the most recent meeting in October 2017 showed the registered manager had raised concerns about documentation not being fully completed, including care reviews and daily notes. The registered manager told us they were in the process of installing a new computer programme to improve recording of information to ensure information about people's care, support and treatment is accurately documented. The minutes showed this information was shared with staff and that they are to receive training on the new programme.

The registered manager told us they actively tried to engage with people using the service, their families, the public and staff. They were in the process of forming a 'resident / relative, staff and friend committee' of Chalkney House with the intention of giving a voice to all interested parties so that they could be fully involved when making decisions about ways to improve the service. They were also looking into sponsoring a local football team or support a pre-school in the area increasing local community involvement with the service. Additionally, notices, including a 'feedback form' were displayed around the service to enable people, their family or friends to give feedback about the service internally and to outside agencies, such as the local authority.

The registered manager told us they attended regular management meetings with managers from others services owned by the provider to share ideas and best practice. They had also developed good working relationships with other agencies such as the GP, social workers and district nurses and attend Prosper community events. They told us they have developed networks with Hearing Action who now provide a service at Chalkney House. However, as previously mentioned in the responsive section of this report, there was no evidence of partnership working with other agencies, such as hospices or McMillan nurses for people nearing the end of their life.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People who use services were not protected against the risks associated with end of life. This was because the service had not developed personalised care and treatment plans in accordance with best practice guidance or with the support of other healthcare professionals to ensure systems were in place to provide palliative care and ensure people experienced a comfortable, dignified and pain free death. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people lacked capacity to make informed decisions, or give consent the requirements of the Mental Capacity Act (MCA) 2005 legislation were not being consistently applied to ensure people using the service and those lawfully acting on their behalf have given their consent before any care or treatment was provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with the risks associated with the spread of infection

	because arrangements in place for the ensuring the premises were clean were not effective Regulation 12 (2) (h) How the regulation was not being met: People who use services were not protected against the risks associated with the proper and safe management of medicines because medicines, including controlled drugs were not always obtained, stored, administered and disposed of appropriately. Regulation 12 (2) (g) How the regulation was not being met: People who use services were not protected against risks to their health and safety because risks were not consistently assessed or managed to protect them from harm or the risk of harm occurring. Regulation 12 (2) (a)
Regulated activity	**Regulation**
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People who use services were not protected against the risks associated with their nutritional and hydration needs. This was because where people were at risk of choking or becoming dehydrated, these risks were not being sufficiently monitored or managed, which increased the risk to their health and wellbeing. Regulation 14 (4) (a)
Regulated activity	**Regulation**
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were investigated and responded too, however the outcome and judgements made were not always open and transparent or

used to improve the quality of the service.

Regulation 16

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to assess, monitor and improve the quality of the service were not used effectively to ensure the health, safety and welfare of people using the service. Regulation 17 (1) Regulation 17 (2) (a)