Mr Mark and Mrs Karen Hammond

Chelfham House Residential Home

Inspection report

Chelfham House
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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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 29 May and 7 June 2018.

Chelfam 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.

Chelfam House accommodates to a maximum of 41 people, the majority of whom are living with dementia. There are 38 bedrooms, mostly single rooms many with en-suite facilities, over three floors. The main premises was not purpose built but there is a purpose built extension added. There were 38 people using the service at the time of the inspection.

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

At our last inspection in October 2015 we found the service was meeting the required standards and was rated Good. At this inspection we found the service was not meeting all the required standards.

The audit and monitoring systems in place did not always ensure people receive a safe, effective, responsive and caring service. People were put at risk because staff were not always available to support and care for them. The premises was not always clean, fresh and hygienic. However, this was improved during the inspection. Staff put people at risk by giving them very hot food and drink. People were found in undignified situations, such as left in wet clothing. Unclaimed or no longer needed underclothes were kept for other people to wear. One staff member ignored a call bell that had been ringing for a long time. We found that people had their liberty deprived without lawful authorisation.

We have made recommendations in relation to looking at improvements relating to medicines management, the layout and use of the premises and providing a dignified and respectful service. Recruitment was not fully robust as one check had not been completed.

Staff struggled to understand the full concept of person centred care. Activities were not always meaningful to the person as an individual although there was a range of shared activities and events.

Care plans did not always provide clarity on how staff should deliver care. Fire safety had been compromised, but this was also addressed prior to the end of this inspection.

Staff had a good understanding of how to protect people from abuse and people were protected from discrimination. People's nutritional needs were fully met and there was a varied menu available to them.

People's physical care needs were fully met. No agency connected with the service had concerns about the service. The community nursing team praised the care provided. A district nurse said "The care is very good. Staff are alerted to the slightest concern. I have no concerns. Staff knowledge is good and staff are really good at contacting the surgery." Staff praised their training, which was broad and at times innovative in its approach. Care workers received supervision of their work and felt supported. The registered manager said they needed to address the training and supervision of ancillary staff.

The registered manager had been progressive in finding ways to improve the service. They used training, research and meetings with other professionals toward this end. Care workers talked with passion about the people they cared for, wanting to do their best for the people in their care. They said they were well supported and the registered manager was always available, would listen and act on their suggestions. The provider constantly updated plans to maintain the premises, worked in partnership with, and supported, the registered manager.

We found four breaches of Regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Staff put people at risk by giving them very hot food and drink.

Staff were not always available to provide safe care and respond to people's needs in a timely manner.

The premises was not clean, fresh or hygienic. This was improved by our second visit.

Fire safety had been compromised but was safe prior to the end of the inspection.

Medicine management was safe but this could be improved. We made a recommendation.

Recruitment was not fully robust because one pre employment check had not been completed, although the staff member was known to the service.

Most risks, once identified, were mitigated to protect the person. In one case an identified risk was not being managed as the registered manager had planned.

People were protected from abuse and discrimination.

Is the service effective?

Requires Improvement

The service was not always effective.

Where urgent application to deprive a person of their liberty was required, this had not been done. It was completed prior to the end of the inspection.

The environment did not always provide people with the spaces they needed to enhance their well-being, in particular a lack of quiet space. We have recommended this be reviewed.

Care workers received training and supervision to support them in the role. The need for improved training and supervision for ancillary staff was identified by the registered manager.

The need for consent was fully understood and people were offered choice. This was respected where possible.

There was a high standard of physical care provided. Health care professionals spoke highly of the care people received.

People had a nutritious, varied diet available to them. However, staff did not always recognise people's need for assistance.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

Dignity was not fully promoted in relation to continence and because the underwear of people no longer resident was saved for other people to use.

Response to people's needs did not always demonstrate a caring attitude.
We made a recommendation.

People's views were sought through understand their needs because staff knew them, meetings and questionnaires.

Arrangements were in place to highlight the ethos of dignity and respect when recruiting new staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff did not always meet people's needs in a responsive way, such as providing adequate cutlery for them to eat.

Care plans did not always provide clarity on how staff should deliver care and support.

Research and training did not translate to a person centred approach to care and support. Activities were not based around people's individual needs, based on their history; not meaningful to them and contributing to feeling of well-being.

There was a variety of shared activities and events, which were enjoyed.

End of life care was considered of a high standard by health care professionals and there were further improvements in progress.

There was a complaints procedure and process and people felt confident complaints and concerns would be well responded to.

Is the service well-led?

Requires Improvement

Some aspects of the service was not well-led.

Audit and monitoring systems did not ensure people receive a safe, effective, responsive and caring service.

Opinion was sought through talking to people and questionnaires toward making improvements. Best practice was sought through training, research and professional contacts.

Views from staff helped to find ways to improve the service.

There was a programme of continued improvement and investment into the service. The provider and registered manager worked in partnership.

The registered manager kept the Care Quality Commission, and other agencies, well informed.

Chelfham House Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 29 May and 7 June 2018. Day one was unannounced. We announced day two so that we could be sure the registered provider would be available.

The inspection team consisted of two adult social care inspectors (one a pharmacist inspector) 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.

We used information the provider sent us in the Provider Information Return, received on March 2017. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the service and notifications we had received. A notification is information about important events, which the service is required to send us by law.

We spoke to three people and four people's family representatives. Some people using the service were unable to provide detailed feedback about their experience of life there. During the inspection, we used different methods to give us an insight into people's experiences. These methods included both formal and informal observation throughout the inspection. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not comment directly on their experiences. Our observations enabled us to see how staff interacted with people and see how care was provided.

We spoke with 17 staff, the registered manager, and provider. Following our first visit, we asked the provider to send us additional information, such as policies and protocols.

We looked at three staff records, 24 people's records (including 18 medicine administration records), and other information, such as reports from meetings and investigations.

We received information from Devon and Somerset Fire Service, Devon Quality Assurance and Improvement Manager, Adult Commissioning and Health, Devon County Council, Health & Social Care Community Services Manager - Torridge Cluster, Northern Devon Healthcare Trust, the team manager Barnstaple Community Health and Social Care Team, North Devon Safeguarding Adults team manager and the community nursing service and falls team.

Requires Improvement

Is the service safe?

Our findings

Some aspects of the service were not safe. Staff had sometimes caused unsafe situations meaning people were at risk from harm. For example, one person's lunch became cold. A microwave was used to reheat the meal. When served to the person they shouted out "hot, hot". We tested the temperature of the food when the person had rejected it, and it was very hot. Another person, served a mug of hot milk, took a sip, and said "too hot". We felt the temperature of the cup and assessed it to be far too hot to have been safely consumed. Again, the staff member said the milk had been microwaved. They took the milk away and replaced it with milk of a warm temperature. Staff members, on two occasions, had demonstrated that they did not understand the safety aspects associated with testing the temperature of microwaved food and drinks before serving it to people.

People were not fully protected from cross contamination and infection. At the entrance, and some other areas in the home, there was a very strong odour of urine, faeces, and cleaning chemicals. We found dried on, brown smears on two toilet seats in one bathroom, in which there was also an open (wet room) drain containing fluid and debris, such as tangled hair. Many surfaces in the home felt sticky. There were several chairs with stained seats, one that appeared to be faecal staining. The service did not look clean and was not fresh. Strong and unpleasant odour remained, but had been much reduced, by our second visit. The previously found areas of, (apparent) faeces had been cleaned. We saw one commode seat was worn and pitted. It posed a risk of infection because it could not readily cleanable in its current state. The commode pan was clean but appeared stained from continued use. The registered manager and provider said they would review old equipment and have it replaced.

An infection control policy, dated 21 September 2017, did not contain information sufficient for the needs of the service; this had the potential to increase risk to people. For example, soft 'toys' were not included in a section called 'Indirect Cross Infection'. Although there were many soft 'toys' for people to handle there was no mention of keeping these clean and in a hygienic manner. We saw that one person had, what appeared to be, faeces under their nails. There was a risk of passing bacteria from one person to another. The registered manager said all soft 'toys' were washed, that cleaning staff had a "routine" but not a written schedule so cleaning could be checked against the schedule.

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

Two people told us that their rooms were cleaned daily. Health and social care professionals who visited the service said they had not noticed any bad odour at those visits. The registered manager explained current difficulties managing some people's hygiene needs due to their complex behaviour. People's continence needs were under regular review, through the district nursing service assessment. Care workers confirmed they received the infection control training. A housekeeper/laundry worker believed they had not received infection control training but the registered manager said there had been e learning completed shortly after their employment.

Staff confirmed they had personal protective clothing available to them. There was a system for handling soiled laundry, to minimise staff needing to handle it. Laundry equipment was suitable for the needs of people using the service. The service had achieved the top food hygiene rating.

Staffing arrangements did not always keep people safe because staff were not always available to cater for people's immediate needs and keep them safe.

We found a staff member, who said they were responsible for the needs of 15 people, struggling to provide safe care. For example, they called for assistance when someone requested the toilet. It took four minutes for a staff member to respond, during which time another person had picked up a fire extinguisher and was carrying it down the corridor, posing a risk to themselves and others.

There were not enough staff available to provide people with the level of individual support they required during their lunchtime meals, over both days. For example, one person's meal became cold whilst they waited for assistance.

During the morning, when a person needed immediate assistance due to incontinence, there was no member of staff in the lounge area to assist them.

One person asked another person using the service to help them up from a seat. A care worker came over to help. The person then asked to be assisted to go to their room. The staff member said, "I can't leave the site for a moment" and so the person left the room alone. We saw them negotiate their way around a cleaning trolley as they walked along the corridor.

People said they had not always felt safe. One said, "I don't really feel safe, that's why they put the gate up, (people) used to just walk in, stand in front of my television, go through my drawers touch my stuff, they still come up but they can't get in now." Many doors had gates to prevent people wandering into their room. This indicated that staff were not always available to engage with people and be available to provide for their support needs.

There were systems in place to decide staffing numbers and allocation but these were not being effective. For example, a 'staff tool' was used to look at people's changing needs, review staff hours, and staff deployment within the home but staff were not always available to provide people's care in a safe and timely way. An allocation book informed staff which areas of the home they were to work. The allocation book for 21 May 2018 showed that six care workers were allocated to work 8am to 2pm and five to work 2pm to 8pm. In addition, on each shift was a senior in charge. They were supported by catering, cleaning and laundry staff. Care workers were also allocated some cleaning and laundry duties, and providing activities for people, as part of their allocation. Between 8pm and 8am there were three care workers. We saw staff around the home but they were not always available to provide care and support to people when needed.

The service Statement of Purpose, provided at the time of the inspection, stated that the service employed eight senior staff, three cooks,/kitchen assistants, two full time cleaners and a full time maintenance person, in addition to care workers. However, these arrangements did not always keep people safe or meet their needs in a timely manner. The registered manager said they recognised that there had been issues during the inspection relating to meeting needs in a safe way but they believed their staffing numbers were sufficient, based on the use of the staff assessment tool.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us, "I ring my bell when I need help; they come fairly quickly, if there is an emergency I have to wait." We asked staff how well the staffing arrangements worked. One said, "I think we could do more". Two said they thought some staff worked harder than others did. Two other staff said, "We feel we can keep people safe. Staff are very aware."

People were given their medicines safely, although there were some recommendations for improvement to the way some medicines records were kept.

There were no people looking after their own medicines at the time of the inspection, but there were policies in place if it was safe for them to do this. Staff recorded the administration of medicines on Medicine Administration Record (MAR) charts. A sample of 18 people's MARs showed that people were given their medicines correctly in the way prescribed for them. Also recorded were the application of creams and other external preparations. The supplying pharmacist printed most MAR charts, but there were handwritten entries on three people's charts that had not been double signed as being checked by a second member of staff. This could lead to the risk of errors, and is not in line with current guidance. However, these entries were correct on the charts we saw.

There were suitable arrangements for ordering, receiving, storing, and disposal of medicines, including medicines requiring extra security. Storage temperatures were monitored to make sure that medicines would be safe and effective. The temperature in the medicines refrigerator was suitable; however, the maximum and minimum range was not being recorded. This was identified at a recent audit by the supplying pharmacy and the manager told us that new forms were being introduced make sure that medicines were always stored at suitable temperatures.

We recommend that the recording of some aspects of medicines management are reviewed, particularly the process for handwriting additions to MAR charts, and the recording of refrigerator temperatures.

People were given their medicines at lunchtime in a safe and caring way. Staff spent time encouraging people to take their medicines correctly. People were asked if they needed any medicines prescribed 'when required' such as pain relief. There was information about people's individual medicines, and policies available to guide staff on looking after medicines safely.

Training had been provided to staff giving medicines. Competency checks were in place to show they gave medicines safely. There was a reporting system so that any errors or incidents could be followed up and actions taken to prevent them from happening again, although the manager told us there had been no reported errors recently.

Fire safety had been jeopardised because a fire door could not be opened as they key was missing.

Owing to a person, leaving the premises from a first floor lounge exits had key locks. Devon and Somerset Fire Service had agreed this and recommended interfacing all final fire exit door to existing fire alarms, so the doors would open automatically should a fire alarm be activated. No timescale had been required. Many, but not all, of the fire exits now had a key in a key safe, next to the door so, in an emergency, the door could be opened. The first floor lounge key was to be kept hung near the door but at our first visit the key could not be found and so the door could not be opened quickly in an emergency. It transpired that a staff member had taken the key home by accident. Based on our feedback after day one, an arrangement to fit the recommended safety works was brought forward.

Records of a staff meeting dated April 2018 showed that at that point not every person had a personal

evacuation plan in place. When we inspected these had been completed.

Fire safety had been discussed at a staff meeting, April 2018. This had led to a change in procedure should an alarm be activated. Staff confirmed the new procedure was in place, that they received training in fire safety and they felt confident how to respond to an alarm.

A Devon and Somerset fire officer visited the service on 15 June 2018. They reported that the service now had an integrated fire safety system, staff had a good understanding of fire safety, the registered manager took fire safety "very seriously", and there was good progress in fire safety management.

The service employed a maintenance person who worked closely with the provider to maintain safe premises, working through maintenance and upgrading in line with an assessment of priority.

Recruitment arrangements protected people but this had not been followed for one recruitment file we reviewed. Recruitment policy included pre-employment checks including references from previous employers and Disclosure and Barring Service (DBS) checks. A DBS check helps employers to make safer recruitment decisions by providing information about a potential staff member's criminal record and whether they are barred from working with certain groups of people. We looked at three staff records. Providers are required to ensure they have information from the most recent employer, in particular if that was in a care setting. One person had been employed with two references. However, these were not specific to a request from the service and so the referee would not have known the references were for the role of care worker. A third reference, we were told from the last employer, was shown. However, it was unsigned and undated and so could not be accepted as evidence of previous employment history. The registered manager said she had not noticed this. However, they said that they had known the staff member prior to the employment. They then rang that previous employer to check information about that employment.

The service safeguarding policy tells staff that, "If in doubt, even the slightest doubt, ask for advice." Staff had discussed and followed up on one situation where they felt a staff member might have acted inappropriately. This showed that staff were actively protecting people. Contact details for the local safeguarding of adults team was provided for staff and clearly displayed. The policy demonstrated that the registered manager worked in line with local safeguarding of adults policies and procedures.

To protect people from discrimination the service had a Diversities and Equality policy. The registered manager said this was discussed with staff at supervision meetings and they now had a better understanding of this form of protection. The registered manager gave an example of one person, who did not like crowds, now going out with staff on a one to one basis.

The service understood the importance of protecting people against inappropriate restraint. The registered manager said there was a policy called 'Managing aggression and restraint' which they had produced taking advice from the Northern Carehome Trust. When considering restraint in the person's best interest the principles of best practice had been applied, for example when purchasing a specialist chair for a person who kept slipping out of other chairs.

Where risk had been identified staff worked hard to keep people safe. For example, risk assessments included falls, use of gates at the entrance to people's rooms, leaving the premises without support, and monitoring people's weight. The registered manager monitored accidents and no person had sustained a serious injury within the last 12 months. One person had recently been moved from the middle to ground floor. Staff said this was because "He is becoming more anxious and requires extra monitoring". Staff referred people to a 'Falls team' for advice on a regular basis. Aspects of health and safety were addressed

in staff meetings. This showed there was concern for people's welfare and a desire to keep people safe.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had liaised with appropriate professionals and made applications for people who required this level of support to keep them safe. Two of those applications were authorised, whilst the others remained pending. However, two people were actively wanting to leave the premises. For example, one person became upset and anxious during the morning asking staff "Can you tell me when I'm going home, I'm really, really cross". Staff offered reassurance and used tactics to divert the person's attention. The second example was a person repeatedly trying to open exit doors and ask to go home. Staff using the tactics of diversion, for example "Come and have a cup of tea", managed this.

We confirmed with the registered manager that they had not recognised they were unlawfully depriving these people of their liberty and they needed to take immediate action. Following that conversation, they applied for Urgent Authorisation to deprive the two people of their liberty, for their protection.

This is a breach of Regulation 13 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before people received any care and treatment staff tried to gain their consent and act in accordance with their wishes. We saw staff involving people in their care and allowing them time to make their wishes known using individual cues, such as looking for a person's body language and spoken word, for example. People's individual wishes were acted upon where possible, with their safety in mind.

Staff understood how to support people if they did not have the mental capacity to make decisions for themselves, about managing their medicines, for example. The registered manager understood that people's capacity must be assessed per decision to be made. People's capacity to make decisions about their care and support were assessed on an on-going basis in line with the Mental Capacity Act (MCA) (2005). People's capacity to consent had been assessed and best interest discussions and meetings had taken place. For example, for suitability of placement. This demonstrated that staff worked in accordance with the MCA.

Staff had worked to make the environment more 'dementia friendly'. To that end, the walls were decorated with art works, and there was information for people in large, coloured pictorial signs, showing, for example, the situation of the toilet.

A 'sensory room' was shown. When asked to explain the concept of the sensory room a staff member told us "The intention was for it to be for people in the later stages of their life, it doesn't work because everyone goes in there". The sensory room was in a position where people needed to walk through to access the kitchen and so it was not a peaceful space.

The service Statement of Purpose included that there were five lounges available to people. We observed that throughout the inspection, there was sound from the televisions in the lounge areas where people were seated. One television was turned off on the middle lounge for lunch, but replaced with music. There was music in the sensory area that did not always appear appropriate, as it was 'pop' music, not calming. We found there were no quiet areas for people to sit. During the morning, one person started to become agitated. They were attempting to communication with another person but the sound from the television was compromising their attempt.

The dining areas did not provide enough space for people to dine together, or easily. When we observed lunch on the second day, four people sat at a dining table and six people were sat in armchairs. Overlap tables were provided for four people. Two people were not provided with a table. We saw them trying to eat their pudding with it on their lap.

We recommend a review of the layout and use of the premises in line with current good practice guidelines.

People were benefitting from a recent initiative of having a kitchenette near the first floor lounge. This helped give the area a homely feel, and gave people the opportunity to help with kitchen activities if they wished to.

People said staff were able to meet people's needs and that they had the necessary skills to care for them.

People's physical health care needs were well met. A district nurse said, "The care is very good. Staff are alerted to the slightest concern. I have no concerns. Staff knowledge is good and staff are really good at contacting the surgery." There was a low number of pressure sores at the service, for example; people were repositioned on a regular basis, as per their care plan and pressure relieving equipment was in place.

Other agencies said, "No concerns about care", "Good reports regarding care and management. Is always responsive to our queries and works well with us when there are issues regarding resident (or possible new residents)" and "This service is very receptive to our input and attend the majority of learning events/link groups we offer".

Care workers knew how to respond to specific health needs. They spoke confidently about the care practices they delivered and understood how they contributed to people's health and wellbeing, repositioning people in bed, for example. We observed staff holding discussions with health care professionals, ensuring people's health care needs were being addressed. People were supported to see appropriate health and social care professionals when they needed, to meet their healthcare needs. There was evidence of health and social care professional involvement in people's individual care on an on-going and timely basis. GP, psychiatrist, community health services, and social workers, for example.

Care staff had completed an induction in line with the Care Certificate when they started work at the service. The Care Certificate sets a minimum standard that should be covered as part of induction training of new care workers. The induction required new members of staff to be supervised by more experienced staff to ensure they were safe and competent to carry out their roles before working alone. Staff induction was signed off once the staff member's competency was established.

Care workers said the training they received was "Very good." A domestic worker was "Not sure" if the training they had received was sufficient for their role.
The majority of training was on-line, included aspects of health and safety, and conditions which affecting people. The registered manager was trained to provide training in moving people safely and so that advice and instruction was readily available to staff. We observed that staff were using equipment for moving people safely, such as slide sheets. Training in oral health was planned and toothbrushes had been purchased so care workers could experience what it is like to have another person clean your teeth for you. North Devon nurse educators provided staff with some training. There had been recent 'sepsis aware', diabetes, and safeguarding study days, for example. This showed the range of training which was available to staff and which they said they appreciated.

Staff were encouraged to undertake qualifications in care. Toward those qualifications, one staff member had completed a research project from which there had been changes to the environment, with a view to helping people live with the condition of dementia. Some staff had completed qualifications in dementia care.

Domestic staff were less sure about the training they had received and the registered manager confirmed their training was less extensive. They said, "I need to look at considering domestic staff as much as other staff, this applies to training and supervision."

The organisation recognised the importance of staff receiving regular support to carry out their roles effectively. The registered manager had a matrix to ensure each care worker received supervision of their work. That supervision included observation, followed by feedback to the staff member. This helped them look at where improvement could be made. This showed that they recognised the importance of good practice and supporting staff to improve.

People received a variety of nutritious food and drink. People said, "They don't ask me what I want to eat, they just bring it up". Another person said, "They give me a lot of mash, they don't tell me what I'm having, I ask the girl when she comes in what is it". However, we observed a staff member asking people if they wanted fish pie or jacket potatoes for lunch and the chef said choices were offered to people. A varied menu included dishes such as roasts, sweet and sour chicken, and lasagne. A staff member said, "(The person) likes a pasty. People can have whatever they want." Baskets containing fresh fruit, crisps, chocolate, and biscuits were available to people on the ground and first floors. We saw people helping themselves to those snacks.

Some people required food, which was specially prepared, to reduce the likelihood of them choking. There was clear information to inform both the catering staff and care staff about this. Where people had special dietary requests, such as vegetarian, vegetarian options were available to them. Information about people's likes and dislikes was available to inform meal decisions.
People's hydration need was met, tea and coffee were served during the day, and squash was available at lunchtime, for example.

Where a person's diet was a concern, staff monitored this, shared information with the district nurse and GP and followed up on any advice.

Requires Improvement

Is the service caring?

Our findings

Some aspects of the service were not caring although management and care workers expressed a strong desire to provide a caring and compassionate service to people. The registered manager said that staff were trained to treat people with dignity and respect.

We found three drawers in the laundry completely full of underclothes. Staff said these would either be clothing unlabelled and so could not be returned to the person, or they might be from people no longer at Chelfam, if the person had left or died. A staff member said they were used for "spares" for people, when asked why they were kept there. This meant that people were sometimes being clothed in other people's underwear. The registered manager said this was not what they wanted and they had addressed this with staff. They were frustrated this was still happening.

One person, who appeared to be agitated and unhappy, threw a beaker of squash over another person. Staff responded promptly to reassure the person and mop up their wet clothing, however they did not offer to take them to their room to change and so they ate their lunch in damp clothing. There were no staff interactions with the person who threw the water, who continued to present as agitated and asking to go home and so that person continued to appear unhappy. Staff said they knew the person would become more upset if they intervened.

People had very complex needs and staff struggled to keep them from undignified situations. We witnessed two people being incontinent in the presence of other people in lounge areas, for example. One refused interventions from staff, but a staff member managed the situation by gently coaxing the person and eventually gained the consent to assist them to change their clothes. Some people would allow only a few staff to provide their care, which affected the amount of personal care they received. The registered manager said they did some spot checks to see what level of personal care people received, checking for use of their toothbrush, for example.

Staff did not always respond to people requesting assistance. Whilst observing in a lounge we heard a call bell ringing for a long time and so we left to look into why this was. A member of the house keeping team, only a few feet from the person's room, had not taken any notice of the bell. They hadn't alerted any care staff. When we asked them about it, they went to see why the person was ringing. They returned saying the person "Didn't feel very well and was sitting on the side of the bed with their hands in their head." A care worker then arrived and went to the person. The care worker said, "I'm trying to catch up with everything." This meant the person had been left feeling unwell for a period of time without anyone attending to them.

We recommend that the arrangements for providing a dignified and respectful service be reviewed.

A new interview questionnaire, to be introduced immediately, was shown us by the registered manager. This included question based on the values at the service, such as caring, compassion, empathy, and love, for example. This was because they wanted those values to be a priority at the service.

People's views were sought through getting to know the person, through a monthly family and resident meeting and through questionnaires.

One person said, "Staff are alright, kind, they help me get up; give me a good wash."

Care workers spoke passionately about the people they cared for. Their comments included "If I found someone crying I wouldn't walk past them, I'd find out what was wrong" and "There is always time for cuddles."

Staff demonstrated kindness and were observed offering hugs and physical contact with some people. One staff member said, "When people are distressed some staff speak gently, give them a hug; some are more compassionate than others".

We asked one senior care worker their definition of 'caring'. They said "Good care is having plenty of patience, giving choices, respecting their past and explaining things to them. Most of them have dementia". They were unable to explain the needs of a person admitted eight months previously, when we asked about them. They said they were "not sure". Other staff did have insight into peoples' past, knowing what a person's career had been, for example. Staff said, "I think we're 150% caring".

We spoke with three relatives who were visiting, they said they were free to visit whenever they wished and were always made to feel welcome. One relative said, "I come at any time, it always feels that there is a calm and peaceful atmosphere, even though I know some people are tiresome". A health care professional said how caring the registered manager was, saying "The management are very supportive to clients families and will often provide transport for them to visit if they have no other way of getting there". This showed a strong desire by the service to maintain strong family relationships for people.

Requires Improvement

Is the service responsive?

Our findings

Research and training did not always translate to a person centred approach to care and support.

A staff member had undertaken a project to look at improving person centred care. They recorded 'I believe the changes we make to the care plans will improve each person's quality of life, increase their well-being and empower them, encouraging them to reach their goals and we can also give them the support and assistance needed to take more control of their lives.' It was recognised that it would take time to gather the information needed to make those improvements to people's care plans.

Staff struggled to understand the full concept of person centred care. Two told us, "We have an allocation book, so we always know what we are doing, bathing and showering people, activities, tea-trolley, staff meetings". This meant those care workers were identifying routine tasks of daily living with providing person centred care.

We found it difficult to find any information in the initial assessment, through care planning and staff allocation, about people's emotional needs. Staff told us that they believed they practiced person centred care. They gave examples: "Sitting down and talking to them" and "Treating people as an individual". Staff were asked to explain their understanding of the model of dementia care they were following. They said, "It's about no uniform, reducing agitation, encouraging staff to work from the heart; we try to achieve compassion". The service had a no-uniform policy to make the service homely and help people feel relaxed in a non-formal setting. When we observed staff interacting with individual people they did work from the heart and achieve compassion, but we saw they spent most of their time completing tasks.

Care plans did not always provide clarity on how staff should deliver care. The term 'monitor' was frequently used, but with no explanation of what that should be. A staff member said monitoring was not "formally" recorded, "not written down anywhere" other than in a daily observation book, which did not include any method of evaluation. The staff member said that monitor meant, "Just keep an eye on it".

We checked some care plan information against what was happening. For one person it said, "Wears glasses all the time". They did not have their glasses on when we checked. A care worker showed us that they were in a box in an office.

We looked for examples of person centred care. Staff knew that one person had a high status profession in the health service prior to their retirement. We saw the person walking around a lot and asked the staff what activity that person might find interested them. The staff member offered them a soft toy, which the person refused. We saw no example of people engaged in meaningful activities based on a person's life history, interests, or hobbies and staff we spoke with were unable to give us examples. Staff talked passionately about the difficulties in getting information about the people they cared for. They gave an example of where, at a funeral, they found a lot about a person they had not known in the years they cared for them. It had made them sad that they may have missed opportunities to improve the person's life.

There were regular group activities for people. These included visiting entertainers, lunch on the patio, 'themed' days, dog visits, bingo, an Easter egg hunt, and bonnet making. Some of the activities were organised with involvement from the local community, largely due to a 'Residents and Friends' Committee. They arranged visits to a local plant nursery for up to six people. There were visits from the Local Women's Institute and a village singing group. Church services were held on a regular basis.

One person using the service said it was impossible to talk to other people and that they sometimes got bored. They said they would like to be taken out on an individual basis. They said they did not feel able to communicate these needs to the staff. However, the registered manager gave an example of where they would take one person out, on their own, on a regular basis because they had not liked crowded situations.

Staff worked hard to meet people's needs in a responsive way but did not always achieve this.
One person was attempting to eat their meal with a knife. It was some minutes before this was discovered. A fork was then offered. A pudding was given to one person but this was then taken away as they had not attempted to eat it. We pointed out that they may have required assistance. This was provided and the person ate the pudding. Staff did not always see where people needed help.

We looked at how the provider complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. People receiving support were living with dementia and had varying communication abilities. Staff worked hard to communicate with, and understand each person's requests and changing moods because they were unable to verbalise them. There were arrangements in place for advocacy should a situation arise where a decision needed to be made and the person needed that independent support. Pictorial information around the home also helped people find their way.

Community nurses said they had no concerns about the end of life care staff provided and that care was "Very good" at Chelfam House. The service used the 'Gold Standards Framework'. This is a framework of training, which enables front line staff to provide a gold standard of care for people nearing end of life. One staff had almost completed this, and from their training the service had "completely overhauled and improved" their end of life care, with more improvements planned. With the intention of meeting people's wishes in relation to advanced care planning, the registered manager had sent questionnaires to people's families about this.

The service had a complaints policy and process, which was displayed in some areas of the home and given to each person and their family members. The complaints procedure set out the process for making a complaint and included the address for the Care Quality Commission and the Local Authority, should people want to take the complaint further. People's families said they felt very confident to take any complaint or concern to the registered manager and that this would be acted upon.

The service had received one complaint in the previous 12 months, which mostly related to laundry. A dedicated laundry worker had been introduced, based on the findings of the complaint. The Care Quality Commission was aware of the complaint and the investigation.

Requires Improvement

Is the service well-led?

Our findings

The service was not well-led because the audit and monitoring systems in place did not always ensure people receive a safe, effective, responsive, and caring service.

The service had a manager who registered in 2013. 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.

The registered manager said audits were competed once a month. These included, observing hand hygiene, and infection control. However, people's safety and dignity was being compromised by a lack of cleanliness and, at our first visit, very strong unpleasant smells, which staff had not noticed and addressed.

Quality assurance systems in place had not identified a number of other concerns we found at the inspection.

Two people's liberty was being deprived without authorisation, but this had not been identified.

Although there were systems for calculating staffing, several examples showed were people were unsafe or their needs were not met in a timely manner. We observed some staff was struggling to cope.

A fire door key, taken home by mistake, had compromised safety should there be an emergency. Staff had twice given people food or drink which was too hot, leading them to shout out. Mealtimes were not always managed well.

Some actions were identified from monthly medicine audits to help improve medicines management in the service, although the areas we have recommended for improvement had not been identified by these internal audits.

The registered manager told us that "one to one support" was required for one person, due to their complex needs and associated risks in relation to another person. They later told us that "extra observation" was sufficient. Several times, we saw the person without a staff member and when we asked staff about this, they were unaware of any special staffing arrangement for that person.

Despite research and training staff did not understand, and were not always providing, person centred care. This was because staff did not always know enough about people to fully understand their emotional needs or have the insight into how to provide them with activities, which were meaningful to them. Care planning and staff practice was predominantly based on meeting physical needs, and task orientated.

This is a breach of Regulation 17 of the Health and Social Care Act 2008

The registered manager was keen to hear people's opinion of the service so they could look at continuing improvement. They sought feedback from people, staff, and health care professionals. There was a monthly meeting for residents and family, for example. The service magazine called the Chelfam Chatterbox included, "This (meeting) gives us the opportunity to informally chat about Chelfam and what we can do to improve things."

An improvement plan was put in place following questionnaires completed by people in November 2017. We checked and found that actions had been taken to meet the plan and make the requested improvements. This included people who liked to get ready for bed early having a dressing gown they could wear. The registered manager was visible throughout the day and appeared to have a good relationship with families visiting.

Regular audits and monitoring included people's weights and diet, records, complaints, accidents and incidents and prevention of pressure damage. The provider did a weekly visit. This was to discuss any maintenance and issues relating to the premises and support the registered manager in their role. Where staff performance required addressing, this was done. Records from staff meetings showed how different issues were highlighted. Staff had the opportunity to raise was what important to them and had taken concerns to the registered manager, standards of moving and handling practice, for example.

A 'Projected maintenance and Improvement Action Plan' showed how problems were identified and prioritised. This included upgrading the lift, installing an en-suite bathroom and redecoration.

Improvements, where identified, were followed up. It had been found through observation at mealtimes that this could be improved. The registered manager said, "Mealtimes were going wrong". This led to a meal time plan which included who had eaten and who had refused. Later a staff member found that one person, although they had refused their lunch did eat two puddings, and so puddings were included in the monitoring.

Training was based on research-based practice, end of life care for people living with dementia, for example. The registered manger attended a manager's forum, where they received a presentation from the fire service, for example. One staff member had signed up to be the home's nutritionist and attended quarterly meetings organised through Northern Devon care homes team.

Staff said the service was well led, they said because they used allocation books so they knew what they needed to do. They described "honest" staff meetings. One said, "You can always come to (the registered manager). I'm always moaning but things are always followed up".

The service met the legal requirement of displaying the service rating, having a statement of purpose and notifying the Care Quality Commission as required.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not done all that was reasonably practicable to mitigate risk to people. . The provider had not kept the premises clean, fresh and taken sufficient precautions against the risk of infection or cross contamination. Regulation 12, (1) (2) (b) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were deprived of their liberty without lawful authority. Regulation 13 (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have adequate audit and monitoring systems in place to ensure people receive a safe, effective, responsive and caring service. Regulation 17 (1) (a) (b)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider had not ensured the staffing arrangements kept people safe or provided adequate care and support in a timely manner.

Regulation 18 (1)