Coate Water Care Company (Church View Nursing Home) Limited

Chapel House Care Centre

Inspection report

Horton Road
Gloucester
Gloucestershire
GL1 3LE

Tel: 01793821200
Website: www.coatewatercare.co.uk

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Chapel House Care Centre on the 13 and 14 March 2018. Chapel House Care Centre is registered to provide accommodation, nursing and personal care to 41 older people and people living with dementia. Since October 2017, the service also works in association with local clinical commissioners to provide six acute beds and 10 'step down beds' to facilitate the discharge of 'medically well' people awaiting care packages or assessment from the local hospital.
At the time of our inspection, 20 people were living permanently at Chapel House Care Centre and 13 people were receiving temporary support as per the agreement with local clinical commissioners. Chapel House Care Centre is located next to Gloucestershire Royal Hospital and close to a range of amenities. The service is split over three floors with communal spaces on each floor. The service has a secure garden which people could enjoy. This was an unannounced inspection.

We previously inspected the home on 26 January and 1 February 2017 and rated the service as "Requires Improvement", as we identified that improvements were still required in relation to people's person centred care and the quality assurance systems needed to be embedded further. At this inspection we found these improvements had been embedded and sustained and the service was rated 'Good' overall.

There was a manager registered with CQC at the service, however they had very recently left the service. An interim manager was now in place and worked alongside the Operations Manager and Director of Operation who assisted in providing the day to day management and support. The provider was in the process of recruiting a new manager for Chapel House Care Centre, who they would support through the registration process with CQC. 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.

People were safe living at Chapel House Care Centre. There were enough staff deployed to ensure people's needs were being met. People received the support they required to meet their health and wellbeing needs. People enjoyed an active life within Chapel House Care Centre.

People who were staying at Chapel House Care Centre for short term respite or those returning to their own homes, were supported to maintain their independence and wellbeing by staff employed by the provider and the local clinical commissioning group.

Care and nursing staff treated people with dignity and ensured they had their nutritional needs met and received their medicines as prescribed. Catering and care staff were aware of and met people's individual dietary needs. Staff spoke positively about the support and communication they received.

Care staff were caring and were aware of people's health needs. Care staff treated people with dignity. People and their relatives felt their concerns and views were listened to and acted upon. Relatives told us

the management team was responsive and approachable.

The manager and provider had implemented system to monitor and improve the quality of service people received at Chapel House Care Centre. Representatives of the provider were working with healthcare professionals to evaluate the service they provided in association with the clinical commissioning group. The provider was working with healthcare professionals to develop this service and assess the benefit it had on people and healthcare services, including the local hospital.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The risks associated with people's care were managed and people were supported to take positive risks. People received their medicines as prescribed.

There were enough staff deployed to meet the personal care needs of people. People felt safe living at the home and staff understood their responsibilities to report abuse.

Is the service effective?

Good

The service was effective.

Care staff had access to the training and support they needed to meet people's needs.

People were supported to make day to day decisions around their care. People were supported with their on-going healthcare needs, including rehabilitation to return to their own homes.

Is the service caring?

Good

The service was caring. Care staff knew people well and what was important to them.

People's dignity was promoted and care staff assisted them to ensure they were kept comfortable. People's independence and individuality were respected.

Is the service responsive?

Good

The service was responsive. People's well-being needs were being effectively acted upon to ensure people received the support of healthcare professionals.

People enjoyed their life in the home and had access to ad hoc activities which met their individual needs.

People and their relatives told us they felt involved and their concerns and complaints were listened to and acted upon.

Is the service well-led?

Good

The service was well led. Consistent management support was available at the service, even though there had been a recent change with the manager.

People and their relative's views were sought and they felt the provider and management were responsive to their concerns.

The provider was monitoring the effectiveness of the service and was proactively working with other healthcare providers to provide a new service type to meet people's needs.

Chapel House Care Centre

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 was 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 13 and 14 March 2018 and it was unannounced. The inspection team consisted of an inspector, a specialist advisor with a nursing background and an expert by experience. The expert by experience's area of expertise was in caring for older people. At the time of the inspection there were 33 people living or receiving respite care at Chapel House Care Centre.

We requested and reviewed a Provider Information Return (PIR) prior to this inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the service, which included notifications about important events which the service is required to send us by law. We spoke with and sought feedback from a range of healthcare professionals, including clinical and local authority commissioners, staff from the care home support team. A GP and three NHS staff involved with the service and development of the home's project with the local clinical commissioners.

We spoke with nine people who were using the service and four people's relative. 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 talk with us. We spoke with 11 staff members; including five care staff, the chef, two nurses, the interim manager and two representatives of the provider. We reviewed eight people's care files. We also reviewed staff training and recruitment records and records relating to the general management of the service.

Good

Is the service safe?

Our findings

People felt safe living at the home. Comments included: "I'm safe, you don't have to worry about me" and "I'm safe, no problems. Relatives told us they felt their loved ones were safe living or staying at Chapel House Care Centre. Comments included: "I wouldn't want my (relative) to go anywhere else"; "I feel (relative) is safe here" and "I'm very happy. I get peace of mind." Information regarding the provider's safeguarding processes including the provider's safeguarding contacts were available for people and their relatives to access on noticeboards within the home.

People were protected from the risk of abuse. Care staff had knowledge of types and signs of abuse, which included neglect. They understood their responsibility to report any concerns promptly. Staff told us they would document concerns and report them to their line manager or the registered manager. One staff member said, "I know I can go to the manager with something serious". Another staff member told us what they would do if they were unhappy with the manager's or provider's response. They said, "If we're not happy with the response, we can go to the head office. Then there is a list of contacts we can go to, to whistle blow". Care and nursing staff told us they had received safeguarding training and the manager and provider were in the process of ensuring this training was refreshed.

The interim manager and representatives of the provider raised and responded to any safeguarding concerns in accordance with local authority's safeguarding procedures. Since our last inspection the provider had ensured all concerns were reported to the local authority safeguarding team and CQC. Care and nursing staff were supported to learn from incidents and accidents to make improvements to people's care and support. For example, accidents or near misses were reviewed and guidance provided to staff to ensure people's health and wellbeing needs would be maintained.

People could be assured the home was safe and secure. Safety checks of the premises were regularly carried out. People's electrical equipment had been checked to ensure it was safe to use. Fire safety checks were completed to ensure the service was safe. Fire exit routes were clear, which meant in the event of a fire people could be safely evacuated. Equipment to assist people with safe moving and handling were serviced and maintained to ensure they were fit for purpose.

People could be assured the home was clean and that housekeeping and care staff followed and recognised safe practices in relation to infection control. People and their relatives felt the home was clean. Care staff wore personal protective clothing when they assisted people with their personal care. Care staff told us how they protected people from the spread of infection. We spoke with the head of housekeeping who spoke confidently about the resources and staff that was available to ensure the home was clean. They said, "We've got a full team, which is great, we get it all done."

People had been assessed where staff had identified risks in relation to their health and well-being. These included moving and handling, mobility, agitation, nutrition and hydration. Risk assessments gave staff guidance which enabled them to help people to stay safe. Each person's care plan contained information about the support they needed to assist them to be safe. For example, one person had clear assessments in

place for staff to follow to protect them from the risk of pressure damage to their skin and to assist them with their mobility. The person required support from care staff and the use of equipment to enable them to safely move around the home. The equipment the person required to support their needs was clearly documented which included their pressure relieving equipment as staff had identified they were at risk of pressure sores on their heels. Staff informed us and we observed they had the equipment they needed to meet this person's needs and to keep them safe.

People were supported to balance their personal wishes with their care and risk assessments. For example, one person enjoyed a daily alcoholic beverage. The person's care plans stated the importance of this drink to the person and any possible impacts it could have. Staff supported this person in accordance with their wishes.

We observed there were enough staff deployed to meet people's needs, however staff and relatives sometimes felt there was not always enough staff to support people on the top floor of the home. One relative and one staff member discussed a situation where they felt one person was placed at potential risk. The manager was made aware of this risk and was taking action to ensure the safety of people. The manager and representatives of the provider were planning to speak with all staff about the deployment of staffing and the support available to staff. A representative of the provider was planning to display the staffing numbers deployed in the home for the benefit of people, staff and visitors.

However, other people and their relatives felt there were enough staff deployed to meet their or their relative's needs. Comments included: "The staffing levels make me feel reassured"; "I can get a member of staff when I need them" and "The staff help (relative), and they are around when (relative) needs."

Records relating to the recruitment of new care staff showed relevant checks had been completed before staff worked unsupervised at the home. These included employment references and disclosure and barring checks (criminal record checks) to ensure staff were of good character. The manager had full control of this process, which enabled them to ensure that staff who came to work at Chapel House Care Centre had the skills, experience and the character required to meet people's needs.

People's prescribed medicines were kept secure. The temperature of areas where people's prescribed medicines were recorded and monitored to ensure people's medicines were kept as per manufacturer guidelines. Where people required controlled drugs (medicines which required certain management and control measures) they were administered in accordance with the proper and safe management of medicines.

People received their medicines as prescribed. Nursing and care staff kept an accurate record of when they had assisted people with their prescribed medicines. For example, staff signed to say when they had administered people's prescribed medicines and kept a record of prescribed medicine stocks and when they had opened people's prescribed medicines. We found people were receiving their medicines as prescribed. We counted people's prescribed medicines, against their MARs and other relevant records. People's stocks were all accounted for by care and nursing staff. Nursing and care staff understood their responsibility to raise concerns if they believed a person had not received their medicines as prescribed.

We observed one nurse and two care staff assisting people with their prescribed medicines in a person centred manner. For example, one member of care staff assisted a person with their prescribed medicines in a kind and compassionate way. They clearly communicated what the medicines were for and asked if the person wanted to take them. They gave the person plenty of time and support to take their medicines. The person was in control throughout, offered choice by the staff member and given a drink with all their

medicines.

Good

Is the service effective?

Our findings

People and their relatives felt the care and nursing staff were skilled and knew how to meet their daily needs. Comments included: "The care staff are absolutely tremendous, they know their stuff"; "The staff are really good here, always approachable"; "They really look after me, they don't mind when I fart, they say they fart too" and "I think they look after (relative) really well." One healthcare professional spoke positively about the commitment and skills of care and nursing staff employed at the home. They said, "Staff have been quite engaging. All staff have the training, and they are really keen to get their skills up together."

Care and nursing staff told us they had access to the training they required to meet people's needs. Comments included: "I have the training and support I need. I feel more confident and I get the support I need"; "The training is okay, I have what I need. I think things are going okay" and "I think we get all the training and support I need. I've asked for more dementia training which they are looking into. I do like it here."

Care staff were supported to carry out additional qualifications in health and social care and develop professionally. For example, care staff working on the first floor of the home worked with people who were staying in beds contracted to the local clinical commissioning groups. They had been trained to support people to maintain and develop their individual skills to enable them to return to their own homes such as completing medicine training and skills to assist them with supporting people to maintain their levels of independence. One member of staff said, "Things have definitely improved. There are dedicated staff on each floor, which helps improve consistency and people's skills."

Nursing staff felt they had the support and development they needed. Nurses told us they were supported to maintain their clinical skills and could seek support to develop their skills alongside healthcare professionals. One nurse spoke positively about the support they receive and told us, "I feel it is a good place to work. I have the skills and equipment I need to carry out my role."

Staff spoke positively about the support they received and felt the new manager was approachable. One member of staff said, "I get all the support I need. The new manager is very approachable." Another member of staff told us, "The manager is really approachable. You're able to go to them with an idea or concern and they really do listen."

Care and nursing staff had an understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and knew to promote choice when supporting people. The 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 lacked mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
Care and nursing staff understood and respected people's rights to make a decision. Staff explained how they embedded the principles of the MCA into their practice. Comments included: "One person likes to stay in bed a bit later; we offer them the choice of when they want to get up, have something to eat and drink.

They're in control, we can't force them" and "We talk to them (people). Understand the things they like to do. It's important to sit down and be patient with them."

People's mental capacity assessments to make significant decisions regarding their care at Chapel House Care Centre had been clearly documented. For example, one person sometimes refused to take their prescribed medicines. Assessments had been carried out to see if this person had the mental capacity to make a decision about their medicines. The service worked with the person's family members and relevant healthcare professionals, including GPs to discuss the support they could provide in the person's best interests. It was agreed that some of the person's prescribed medicines could be administered covertly if required. There were clear protocols in place for nursing staff to follow. One member of nursing staff told us, "We can administer the medicine covertly, however at present we don't need to."

At the time of this inspection a number of people were being deprived of their liberty within the home. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The manager was aware of their responsibilities to ensure where people were being deprived of their liberties that an application would be made to the supervisory body. Where people were living under DoLS this was reflected in their care plans. Care plans also documented how staff should support people in the least restrictive manner. Where people were under constant supervision or equipment was in place to monitor people's safety and movements, such as sensor mats, this was included in DoLS assessments and relevant mental capacity assessments had been completed.

The majority of people staying on the home's first floor had capacity to make decisions about their care and were receiving support to maintain their independent skills. Staff discussed how they focused on supporting people to do as much for themselves as possible. One member of staff told us, "Our focus is on encouraging people to do things for themselves; it reminds them that they'll be going home. We make sure people are happy and confident when they go home." One person staying on this floor told us, "Yes, they cater for my needs. I would speak out if they didn't."

People's needs were assessed before moving to the service permanently or through the provider's contract with the clinical commissioning group. These assessments were detailed and showed that people's physical and mental health needs had been assessed. Assessments included information in relation to people's nutritional needs and needs around their anxieties and mobility needs. The care plans provided staff with basic guidance on the person's dietary preferences and how they should be supported with day to day choices. Care staff told us that the care plans provided them information on people's health needs.

Where people had been admitted from the local hospital to stay in the urgent care assessment beds and rapid response team beds had their needs assessed prior to and during admission. The provider met monthly with commissioners to discuss how information was shared, to ensure people's assessments were effective and accurate. Omissions in people's care records were discussed at these meetings to ensure that the commissioners and the service were ensured that people's health and care records were reflective of people's needs. One healthcare professional told us, "We have care plan discussion, how much information is required. Communication is good and (support) is available 24 seven."

As part of the homes project with the clinical commissioning group there was daily support from a GP whose surgery was located close to Chapel House Care Centre. The GP told us about the support they provided the service and felt the project had been beneficial.

People's care plans reflected their diversity and protected characteristics under the Equality Act. People's sensory needs had been identified and staff were prompted to make sure people had access to equipment to ensure their continued independence. For example, staff checked people's hearing aids to ensure they were in working order and glasses were accessible.

People had access to health and social care professionals. Records confirmed people had been referred to a GP, continuing healthcare professionals, occupational therapists and physiotherapists. Additionally people were supported to attend appointments when required (such as when families were unable to escort their relatives to appointments). People's care records showed relevant health and social care professionals were involved with people's care.

People and their relatives spoke positively about the food and drink they or their relatives received in the home. Comments included: "There is a lot of choice on a daily basis, there is always soup on the menu which is mostly rich, thick and tasty. It's easier to eat soup when a main meal just seems too much"; "Oh the food is lovely, they cook for me too" and "The food is brilliant, they always eat it." Care staff supported people to have access to food and drinks throughout the day. Fresh drinks were in communal areas which were distributed from special machines and people's rooms and were refreshed daily or more often if required.

People received diets which met their dietary and cultural needs. For example, one person required a gluten free diet. The chef and care staff told and showed us that this person had specific meals to meet their dietary needs. The chef spoke positively about the facilities they had to ensure people had diets which met their health or wellbeing needs. They explained how they were informed of people's changing needs, such as weight loss and people's dietary needs at their assessment. They explained, "If people are losing weights then we can fortify their food, provide fortified smoothies to help enhance their diet."

The premises were suitable to people's needs. Adjustments had been made to the top floor since our last inspection and the flooring had been changed. We were informed the change had been made due to the noise the original flooring caused. People living with dementia were able to orientate themselves around the home.

Good

Is the service caring?

Our findings

People and their relatives spoke positively about the caring nature of staff employed at Chapel House Care Centre. Comments included: "They're (staff) very caring"; "I'm happy here, I get everything I need"; "I can't fault the care staff, they're very caring and compassionate" and "She's happy here, it's brilliant."

People enjoyed positive relationships with care, nursing and other staff. The atmosphere in the home was friendly, inviting and lively in the communal areas with staff engaging with people in a respectful manner. We observed many warm and friendly interactions. Staff encouraged people to spend their days as they wished, promoting choices and respecting people's wishes. For example, one person was feeling agitated. Care staff offered this person the opportunity to go to the home's main lounge and to go outside in the home's garden. A member of staff supported and encouraged the person, and assisting them at their pace. They enjoyed a friendly and lively conversation as they moved around the home.

People engaged staff and were comfortable in their presence. They enjoyed friendly and humorous discussions between each other. People talked to each other and clearly respected each other and were observed talking and laughing with each other. Another person enjoyed having a friendly chat with a member of staff regarding their lunch time meal and the television. Staff had time to assist people with ad hoc activities, for example one person was supported with cleaning some cups and plates. This gave the person a sense of purpose and kept them calm and engaged.

People were supported to maintain their personal relationships with people who were important to them. For example, people and their relatives told us that visitors could visit at any time and there were no restrictions in the visiting times. One relative said, "I can visit any times, there are no restrictions." The service worked with people's families to ensure they were involved in any changes. One relative told us, "The staff let me know if there are any changes. They always ask my views, it's really good."

People's dignity was respected by care staff. For example, when people were assisted with their personal care, staff ensured this was carried out in private. People living at Chapel House Care Centre felt they were treated with dignity and respect and their wishes were respected. We received comments such as: "I can go into my bathroom and have a wash and get dressed in there whilst my bed is being sorted out" and "They will see to my personal care without my being embarrassed at all. I am kept covered at all times."

Care and nursing staff told us how they ensured people's dignity was respected. All staff members told us they would always ensure people received personal care in private and would ensure they were never exposed. Comments included: "We always talk about what we're doing; we support people to do as much for themselves as they can" and "We always ensure care is carried out in privacy. If someone has an accident we work quickly to protect their dignity."

People were able to personalise their bedrooms. For example, people displayed decorations or items in their bedroom which were important to them or showed their interests in their bedrooms. For example, one person's room contained photos of their family and people who were important to them. Another person

had a number of possessions they had brought from their own home.

People where possible were supported to make decisions around their care and treatment. For example, one person's care plan clearly documented their views and also their wants and wishes regarding their end of life care. This person had also made a decision to refuse resuscitation in the event of cardiac arrest. This decision was clearly recorded in the person's care plans. Other people had completed advanced care plans which documented how they wished to spend their final days and what things were important for them to have at the end of their life, such as family and specific music

Good

Is the service responsive?

Our findings

At our last inspection in January 2017, we found people did not always have access to activities which were personalised to their hobbies and interests. People did not always receive their care in a way which was in accordance with their personalised needs. These concerns were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had taken effective action and met the requirements of this regulation

People enjoyed engagement and activities with care staff and activity co-ordinators. People told us there were things for them to do living at Chapel House Care Centre. Comments included: "I'm not bored" and "I like the activities that get us up and going."

People were supported out into the local community and also enjoyed support from external entertainers. We were told that all care staff were responsible for providing activities and stimulation. Activities were tailored to people's individual preferences. For example the staff member told us, "(Person) likes cars, so that's always something we talk to them about and show them pictures."

The staff member told us about the activities they were bringing to the service and the benefit they saw on people's wellbeing. They told us, "We have baking days, making simple cakes and biscuits in the dining room by putting two tables together. I have also arranged quizzes which becomes quite competitive when sitting in a group around a table. I also bring in DVDs of Musicals which they absolutely love."

People were supported to enjoy activities based on current events. For example one staff member told us, "When it was Chinese New Year, we had a Chinese meal and we made Chinese lanterns. We also had a mock Crufts (a national dog show which had been recently televised). A member of staff brought in their Great Dane and someone else brought in a little terrier. They loved it."

Some people stayed at the home for short term support before returning to their own homes. Care and nursing staff employed by the provider worked alongside healthcare professionals employed by the local clinical commissioning group to enable people to maintain their skills, whilst promoting their confidence to manage living in their own homes. We observed people being supported with mobility exercises in accordance with their needs. Staff also explained how they assisted people with the transitions to the service from hospital and to their own homes from the service. They told us, "Some older people are anxious when they come in as it's a nursing home, we need to make them understand that they will be going back home. We are always working on their confidence as we won't be there with them in their home."

The member of staff explained how they tried to ensure people's return to their own homes were as stress free as possible. They told us, "The discharge process needs to be managed properly. We ensure people's records are checked, that people have 14 days of medicines. We arrange transport and ensure medical records are up to date. Everyone leaves with a goody bag, which includes a shopping bag, a mug, a survey and over Christmas time we gave people a calendar."

People's relatives were informed of any changes in their relative's needs. For example, one person's relative told us staff always kept them updated and informed of their relative's needs and wellbeing. They said, "I am told if (relative) falls. The staff tell me how they are and what they're doing about it." People's care records showed where staff had contacted family members to ensure they were updated on their relative's well being.

Staff were responsive to people's changing needs. For example one person's relative told us, "The staff are really good, they know what to do and they inform us when things are changing. We observed staff assisting one person who was anxious. Care staff and management spent time with the person reassuring them and providing them with meaningful engagement. Care staff knew what was important to the person and the triggers of their anxiety. This enabled care staff to ensure their wellbeing was met. For example one member of staff said, "We enable them to do some washing up and dusting. They have special draw, so they can put the washing away and we can then send it to the kitchen."

People knew how to make a complaint if they were unhappy with the service being provided. One person said, "I would go to the manager if I had any concerns." Information of how to make a complaint and key contacts were available throughout the home. The manager kept a record of complaints and compliments they had received about the service. They had clearly investigated these complaints and discussed the outcomes with people and their relatives. For example, one person complained about the care of their relative. A clear response including the actions the service were taking to resolve their complaint, such as agreeing a plan of care and ensuring all staff including agency staff had appropriate information required.

Good

Is the service well-led?

Our findings

At our last inspection in January 2017, we found the provider had implemented a range of quality assurance systems; however they had not been fully embedded. At this inspection we found the quality assurance systems had been fully embedded and were being effectively used to monitor the service being delivered.

The provider had effective quality assurance systems to monitor the quality of care provided and drive improvements when shortfalls had been identified. These audits covered areas such as medicine management, the environment and infection control. Where shortfalls had been identified there was a clear actions recorded. For example, one concern had been identified in relation to medicine fridge temperatures not being recorded consistently and omissions in the recordings of people's prescribed medicines. At this inspection we found that these actions had been taken and nursing and care staff responsible for medicine administration were aware of their responsibilities in relation to the management of people's medicines.

Prior to this inspection the registered manager had left the service. 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. A new manager was now in post and there was additional management cover provided by representatives of the provider. People and their relatives knew who the management team were and how to contact them. Throughout the day we saw the management team engaging with people and taking the time to ensure they were happy. Staff stated the management team were approachable and felt comfortable talking to them.

Since October 2017 the provider had entered into a contractual agreement with the local clinical commissioning group to provide six acute beds and 10 'step down beds' to facilitate the discharge of 'medically well' people awaiting care packages or assessment from the local hospital. Representatives of the provider were meeting monthly with commissioners and a GP assigned to this project to review the service being provided and discuss any concerns or improvements required. These meetings discussed issues such as people's medical records, staff training, people's referrals to the home. They also discussed improvements which could be made to the discharge process, such as ensuring important details such as key safe numbers were effectively communicated. A healthcare professional told us, "The short term beds have in the main been successful in supporting winter pressures from the acute hospital perspective."

The GP attached with the project how completed a contract monitoring report which they shared with us as part of the inspection process and prior to potential discussions around the extension of the contract. This report detailed the problems encountered, such as people's prescribed medicines stocks and management of people's prescriptions. It also documented where improvements had been made following initial problems around inappropriate admissions to Chapel House Care Centre. The GP had documented recommendations for the future including the possibility of implementing electronic patient records especially regarding people's prescribed medicines. The GP stated, "Chapel House provides important and significant extra capacity. With the proposed reduction in community hospital beds and an increasing prevalence of frailty in Gloucester, this capacity will become more vital to ensure the efficient running of the

acute hospital" and "I have enjoyed working with the nurses put in place by (provider) at Chapel House and I feel that we have forged an effective working relationship. This is largely due to consistency and the low turnover of nursing staff since the beginning of the contract."

People and their relative's views on the service had been sought and these views were being acted upon. Each person who was left Chapel House Care Centre to return to their own homes was given a survey which they complete regarding the care and support they received. The overwhelming majority of surveys returned were incredibly positive, with only one person feeling the food and snacks received "required improvement." A representative of the provider was reviewing people's views to identify any improvements which could made for people, such as people requiring to know what menu options were the day before they were supplied.

The manager completed monthly manager's reports which went to the Operations Director to review. These reports provided an overview of any accidents and incidents, including any trends. It also provided a clinical overview on people's needs and staff recruitment and any staff leaving the service. Any events such as an outbreak of infection which had been notified to the relevant authorities was also recorded and followed up by the provider.