Barchester Healthcare Homes Limited

Chalfont Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was unannounced on the first day and took place on the 31 March and 1 April 2016.

Chalfont Lodge provides care and nursing for up to 119 people. The home is divided into five units over two floors. Three units are dementia care units, known as Memory Lane. Sunningdale unit provides general nursing care and Turnberry unit is for people with physical disabilities. During our inspection there were 95 people living at the service.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

In the most recent inspection of Chalfont Lodge in September 2015 we found breaches of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. This was because we found people's medicines were not being consistently managed safely and there was also inconsistency in the completeness and accuracy of records relating to people's care and treatment.

The provider submitted an action plan dated 4 December 2015 which set out the action already taken or to be taken to address this. The action plan indicated the necessary action had either already been completed or would be by the 31 December 2015. The current inspection provided an opportunity to assess whether the action plan had been successful.

We found some progress had been made to address the previously identified areas of concern. For example, there had been an improvement in medicines management and care records. Some concerns remained and progress had been inconsistent which has been reflected in the overall rating of requires improvement.

There had been significant turnover of staff since the previous inspection. This had an impact both on the consistency of care provision and the overall balance of the staff team. Changes to local pay and benefits for staff had been put in place and we were told this had improved the recruitment outcomes for the service. The effect of recent high staff turnover had not yet been fully addressed and people commented about the lack of staff consistency.

People were, however, overall positive about the standard of care they received with some specific exceptions. Where concerns had been raised either internally or externally to the service, the registered manager and the senior Barchester management responsible for Chalfont Lodge, had actively co-operated with others to bring about improvements. These had not, in every case, had time to be fully effective.

The report reflects a service in transition, having faced significant issues around staff retention and recruitment. Whilst progress had been made, with significant management and staff commitment, there

were still areas identified where further improvement was required to provide consistently high standards of care and support to people.

We have recommended the service follows good practice in relation to care plans, staff supervision and medicines practice.

We found breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to the deployment of staff. You can see what action we told the provider to take at the back of the full version 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 consistently safe.

The numbers and deployment of staff did not consistently ensure people received the care they required at the time they required it.

The records of medicines given 'covertly' were not in every case able to confirm people had actually taken them.

People received care from staff who had been subject to a rigorous recruitment process to ensure they were suitable to do so.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not consistently receive formal, recorded supervision to monitor their performance and provide opportunity to discuss their development.

Staff were provided with the training they needed to meet people's care needs effectively.

People told us the quality of the food provided for them was good and that they had genuine choice about what they ate, where and when.

Is the service caring?

Good

The service was caring.

People were positive about their relationship with staff and the standard of care they received from them.

People's dignity was protected and staff treated them with respect.

People were able to express their views about their care and support and how it was provided. They told us they were listened

to when they did.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care plans were not consistently well-completed.

People benefitted from the range of activities provided for them and the team working between activity and care staff.

People had a choice of food and could take their meals where they preferred to do so.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

People were able to comment on the quality of the service they received or they observed. There were, however, delays experienced in putting in place some identified improvements to enhance people's care.

The registered manager provided strong leadership and support to the staff team.

There was significant support available to the service from other agencies and organisations to work collaboratively to improve the quality of care people received.

Chalfont Lodge

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 was unannounced on the first day and took place on the 31 March and the 1 April 2016. The inspection team consisted of one inspector and two special advisors with appropriate backgrounds and experience in medicines and dementia care.

In June 2015 the provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they planned to make. The registered manager provided us with an update of the contact details for health and social care professionals associated with Chalfont Lodge. These were used to send requests for feedback during the inspection process. Throughout the inspection the registered manager and the regional director responsible for Chalfont Lodge within Barchester Healthcare Homes Limited (Barchester) updated us on progress with the areas for improvement they had identified within their PIR.

We also reviewed other information we held about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific significant events the service is legally required to send to us. In addition we requested feedback on the service from 26 community health services, local authority commissioning, and safeguarding or quality assurance teams with experience of the service.

Before, or following our visits, we received nine contacts from people who wanted to share their experience and views about the service. These included concerns about staffing numbers and the standard of care received by people known to them who lived in Chalfont Lodge.

We also reviewed current records of safeguarding referrals made by the service themselves, the CQC or other bodies or individuals.

We looked at 15 care records of people who received a care service, 11 medicines records and checked medicines storage and stock records. We looked at recruitment details for the three most recently recruited members of staff. During the inspection we spoke with 16 members of staff, 11 people who received care and 14 relatives of people who received care.

Requires Improvement

Is the service safe?

Our findings

Since the previous inspection of the service in September 2015 we had continued to receive concerns about staffing levels. These concerns were also reflected in comments made to us during the inspection visits and in the period following, for example, people told us there were "Not enough carers", "Carers are distraught". One relative told us the day after our visit; "The length of time taken to respond to call bells has continued to be a problem and if this is a resident with incontinence problems, can be very distressing". They told us call bell response times had; "Sometimes been one hour or more". They continued; "Specific instances of this problem have been reported to the management and verified by them, only to be told that this is unacceptable." One visitor told us; "I have been told by a number of residents that they have difficulty in getting help when they need it". One person said; "If you press the call button very little happens." During our visits we monitored some call bell response times which were all answered within three minutes.

Another regular visitor to Chalfont Lodge when talking about staffing levels noted; "A similar situation occurs in the dining room, where there are no available carers to help with feeding." One person told us their relative had missed supper on one occasion as staff were not available to collect her and take her. One visiting relative told us; "I must say, on the day of your inspection I have never seen so many staff, whether carers or admin, bringing residents to the dining room."

People told us that on regular occasions, in the recent past, other people's relatives had intervened and helped people at mealtimes when staff were busy or unavailable. One relative said: "They were assisted by another resident's visitor as they had seen them at the table with food and unable to feed themselves.". Another person assessed; "Weekends seem to be a problem in respect of staff. My wife and two others wheelchair bound were left alone in the conservatory with no means of calling for help, after more than one hour, a visitor for another resident arrived who subsequently took my wife to her room."

One relative said; "There is quite a difference between staffing on weekdays and week-ends…it is much quieter at weekends." Another relative told us there was little continuity of staff which meant staff did not always know the preferred routine of his relative. "They were got up too early one day and too late the next, staff appear stressed and some of them are difficult to understand."

As well as negative comments about staffing levels overall, we received a number of compliments about individual members of staff. Also, some relatives had a far more positive view of the care their relative received than others. One relative told us; "Very happy with the care, the staff are very good." Another relative noted: "The staff are good, but there are not enough of them"

We found people's views and actual staffing records were not always consistent. For example, we were told by one person that on a specific date, their unit had only three care staff including those engaged on a one to one basis with specific people. We mentioned this to the registered manager, who provided staffing details, including names and times of staff available on that unit during both the day and night shifts. These showed the assessed staffing level had been fully met. However, other staff told us that on their unit staffing levels at times had only been maintained by as they put it; "Borrowing" staff from another unit.

Staff consistently told us staffing was not always adequate. We spoke with some evening staff as they came off shift and they told us; "There have been recent shifts when there were not sufficient staff on duty." Other staff said there had been recent reductions in staffing. In one instance, for example, from eight to six carers on a unit. Staff comments included; "We are struggling" and "We are just managing." One member of the care staff team said a result of the shortage of staff (as they saw it) was that the quality of care had suffered because they had less time to spend with each person. Two members of staff told us whilst they tried to maintain people's care as a priority, this meant some other tasks were being delayed or not done as well as they should be. They gave examples of the help they would like to give more often with activities, keeping storage spaces uncluttered and "keeping paperwork up to date."

Between the previous and current inspection the number of people using the service had fallen from 102 to 95. The registered manager confirmed staffing levels were intended to reflect both numbers, which had reduced and levels of dependency which were relatively stable between the two inspections.

The provider used a recognised staffing assessment tool which calculated the appropriate number of staffing hours each person required. This took into account the predominant need, for example, young physical disability, nursing dementia, just nursing or just dementia. The level of need was then assessed over 16 domains, for example continence, mobility and nutrition, with each domain rated as high, medium or low. This was then translated into an overall number of total hours care and support required to meet those needs effectively.

The registered manager indicated that actual staffing hours had at times been in excess of the minimum number indicated by the staffing assessment tool. However, they also confirmed there had been some occasions when staffing had fallen below the indicated levels, due to short notice of staff absence and lack of available agency cover. We were previously given examples of how the service had used qualified and appropriately trained management and other staff to reduce the effect of this on people who required care and support. The registered manager indicated these instances had become significantly less frequent since the previous inspection.

The registered manager was supported by the regional director but did not currently have a deputy manager in place. We were told recruitment had been successful and that the new deputy manager would be in post in the near future. One relative said that Sunningdale unit had been; "Without a staff nurse in post for some months now, so the unit lacks management." A health professional told us that it was not always clear who was in charge of the unit they visited or which staff were on duty. They also noted there was no system in place at that time to identify to people or their relatives who their 'key worker' was. Some staff indicated the key worker role was no longer working properly and one relative told us; "The key worker system has been lost". This meant relatives did not always have a consistent contact point when wanting to discuss their relatives' care.

The pressures on staff management and how staff were actually deployed within the service, over five units on two floors, was one possible explanation for the difference in opinion and experience about the adequacy of staffing.

The registered manager acknowledged there could be variation in staff capability. This could significantly affect people's care experience as more experienced staff who knew them well were replaced by newly recruited staff without that level of knowledge about the individual person. We found the more experienced and long-serving members of staff had an impressive knowledge of and insight into people's needs and how they wanted them met.

Overall, we found people who used the service, regular visitors both families and healthcare professionals and members of the care and nursing staff team had significantly less positive experiences and views about the adequacy of staffing compared to the management of Chalfont Lodge.

This represented a breach of Regulation 18(1) of the Health and Social Care Act (2008) Regulated Activities 2014 as it refers to the deployment of staff.

The service continued to face difficulties with recruitment and retention of staff due to the location of the home and the increasing number of local health and social care employers who were competing for staff. This had recently led to the loss of a significant number of staff, at all levels, over a relatively short period. One person reported they had been told by their relative; "There is a high turnover of staff and low staffing levels." This problem had been recognised by Barchester Healthcare Homes Limited and action had been taken to address it wherever possible. This included, for example; enhanced pay, terms and conditions for staff. We were told by the registered manager that this was beginning to have a positive impact on both staff retention and recruitment although both remained a challenge.

We found people were protected by appropriate and effective recruitment procedures for staff. It was positive to find the pressure on staffing had not led to any decrease in the thoroughness of the recruitment process. Newly recruited staff told us this had been rigorous and we looked at three recruitment records which confirmed this.

We monitored medicines practice on the first day of our inspection visit. Overall we found that previous concerns about medicines practice had been addressed including those found in an audit carried out in November 2015.

We saw several examples of good practice in the way medicines were administered and recorded. We found medicines given by means of a percutaneous endoscopic gastronomy (PEG) were administered by appropriately trained staff and recorded as covert medicines.

There were, however, two issues we brought to the attention of the registered manager. One related to the recording of medicines which were only administered as and when required (PRN). Although the administration of the medicine was recorded, the actual taking of the medicines was not. Whilst in most cases this might not pose a risk to the person concerned, there was clearly a risk of self-harm where a person was able to 'hoard', for example, paracetamol.

In another case, medicines given covertly with food, whilst covered by the necessary assessment and authorisation, were recorded as given at the point the food was presented to the person concerned and not when the food had been seen to have been eaten. This meant it was not possible to verify or confirm the medicines had actually been taken.

Two concerns were raised with us following the inspection. These related to the administration of time sensitive medicines. We were told that on occasions medicines had been administered later or at longer intervals than they should be. This was said to have been mainly at week-ends when agency nurses were responsible for medicines. On one occasion we were told medicines had been administered three hours late. In another there had been some confusion over the start and finish dates of a person's antibiotic regime.

We recommend medicines practice in respect of PRN, covert medicines and time-sensitive medicines is reviewed to ensure it is robust and safe.

We found people were protected from avoidable harm because the provider had plans in place to reduce the effects of any systems or equipment failures and to protect people who lived in the service and staff from harm in the event of a major incident. There were schedules in place for the regular maintenance of equipment and the facilities appeared clean and free from obvious hazards during our inspection. During the inspection we saw there was an outside contractor checking and servicing slings and hoists. We were told that any slings which were worn or damaged were replaced. Physical adaptations were in place to help people maintain safety, for example, non-slip flooring in toilets and bathrooms and window restrictors and appropriate security to doors.

There were risk assessments in place to safeguard people from avoidable harm. These assessments included, for example, pressure care, malnutrition, falls or with specific mobility issues. There was evidence these risk assessments had been reviewed where there had been changes in people's health.

Staff confirmed they had received safeguarding training and this was being monitored by the general manager. We saw training records included details of when training had expired or was due. Staff understood safeguarding procedures and told us they were aware of what to do if they saw or suspected abuse.

Prior to the inspection CQC attended a meeting called by Buckinghamshire County Council Safeguarding Adults team. Both the registered manager and regional director for Barchester were present. An action plan was agreed with appropriate timescales for completion.

At the time of this report there were two safeguarding referrals made to the Buckinghamshire County Council Safeguarding Adults team by CQC following the receipt of information of concern. The registered manager and provider were co-operating to address the concerns raised which included the end of life care for one person and the standard of care of a person with a chest infection. In the latter case the information of concern was balanced by some very positive assessments of the standard of care provided at other times.

Requires Improvement

Is the service effective?

Our findings

People received care and support from staff who were provided with the training they needed to do so effectively. Recent significant changes in staff meant the staff team had a wide range of experience and skill. The most recently recruited staff told us they had received an effective induction into the service and this was confirmed by the training records we saw. This meant people received care from staff who had the basic skills and understanding required when they began to provide their care and support. In many cases they had not yet been in post long enough to have undertaken significant ongoing or developmental training. We found some of the newer staff on Memory Lane did not yet have the detailed knowledge of different kinds of dementia and how they impacted on people's care needs. The more experienced staff did which provided them with greater insight into the care needs of the people they supported..

More established staff were very positive about the level of training they received. "Training is very good." They felt this provided them with the necessary skills and knowledge they needed to meet people's needs appropriately. We saw a training matrix which set out training provided and due. A number of established staff told us they thought training had recently improved significantly and welcomed the appointment of a new trainer within the home. We spoke with the trainer and were impressed at their commitment (they had come in on their day off to catch up with paperwork) and also the plans for ongoing training for all staff. One member of staff assessed the current training and new trainer as; "Massive improvement in a short time."

Overall we received quite positive assessments from people who received care and their relatives about the quality and competence of staff, as compared to staffing levels. "My mother says staff are kind and thoughtful and I have witnessed this many times". "The carers are doing their best and are very competent and caring once they get to me"; "Competent staff, can't speak highly enough" were other comments. Particularly positive assessments were made by people about the physiotherapy available in the service; One person told us; "Physiotherapy service is excellent."

As we found at the previous inspection, people still received care from staff who experienced varying degrees of formal supervision. Staff had very different views about the frequency of formal supervision. This could range from monthly to six monthly to none. Some staff told us they had an annual appraisal others had not.

The registered manager recognised that the recent significant change in both management and supervisory staff had disrupted what they said had been an improving position they had achieved. They told us the recruitment of a deputy manager and a more settled staff team would enable them to get staff supervision back on track.

Despite the lack of formal supervision or frequent team meetings, staff nonetheless told us they received other, less formal support and supervision from their line managers and teams and the registered manager. Staff consistently mentioned handover meetings between shifts as being of crucial importance in making sure they were fully aware of any changes to people's needs or situation.

We recommend the registered manager reviews the frequency and consistency of supervision arrangements of staff to ensure all staff consistently receive formal supervision which is recorded appropriately in line with the provider's policies and procedures.

The majority of relatives we spoke with told us they were kept informed of significant changes with people's care needs or situation. One visitor was in the service that day specifically because they had received a phone call from the care staff. One relative told us; "The care is excellent and staff are very patient. The home always ring me with any changes or problems and everyone is very welcoming." Another noted; "There is an open door policy here, I am rung regularly to be kept up to date". Where people had less positive experiences about communication, they thought this was due to frequent changes in the staff providing care.

Two relatives raised the difficulty they and their relative had understanding staff for whom English was not their first language. "They are difficult to understand". This represented a considerable reduction from our previous inspection where it was consistently an issue raised with us. When we spoke with nurses who were undertaking the registration process to enable them to practice in the United Kingdom, they confirmed effective English was one of the requirements which had to be satisfied before registration could be completed.

People had access to healthcare services in the community or from visiting healthcare professionals in the service. For example; GPs, dentists, opticians and chiropodists. Details of these appointments and results of any treatment were recorded in people's care plans.

Since the previous inspection in 2015, CQC received information which suggested partnership working between Chalfont Lodge and other health and social care training organisations had begun to improve following the appointment of the new manager. This progress had also been affected by the recent significant staff turnover. A joint agency meeting, attended by Chalfont Lodge management and local authority and health bodies had established an action plan to ensure the necessary changes were made and progress achieved within a fixed period.

We received positive feedback from people about food. "Food is good" and "the food is good and the restaurant is a pleasant place to eat." We were told by one relative; "Restaurant staff and activities staff go beyond their brief if there is a shortage of care staff." We observed lunch in different areas of the service over two days and found staff supported people effectively and appropriately.

The chef was responsive to requests for alternative meals. They provided people with plated-up examples to help them choose where that was more effective. "Food is also about sight and smell" was their explanation for doing this. This reflected a very holistic approach to meal-times being more than just eating enough. The way food was displayed on the plate when it was pureed was another example where trouble was taken to make the meal attractive as well as nutritious and in a format which was suitable for people who were unable to cope with more solid food.

We saw in those units which provided care for people who lived with dementia, staff were able to sit and eat with people they provided support for. This promoted a calm and settled environment with unrushed support provided and was an inclusive experience for both people and staff. This contrasted with the other comments made above about lack of staff at times to provide the assistance people needed.

Staff had received training in the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS). The MCA provides the legal framework to assess people's capacity to make specific

decisions at a specific time. When people are assessed as not having the capacity to make such a decision, a 'best interest' judgement is made involving people who know the person well and appropriate professionals. Those staff we spoke with understood the implications for their care practice of the MCA. They were aware of how to seek people's consent, using various methods and techniques to assist people, wherever possible to take decisions themselves.

The CQC monitors the operation of the DoLS. DoLS provide legal protection for those people who are or may become deprived of their liberty or to have their liberty restricted. We were informed 57 people were subject to authorisation under DoLS. This was because their liberty, rights or choices were restricted in some way in the way their care was provided. We looked at sample records and found mental capacity assessments and deprivation of liberty safeguard applications had been completed appropriately.

The premises had recently been the subject of significant refurbishment. The passageways and communal areas and individual bedrooms were bright and well-designed and provided people with a pleasant and safe environment in which to live.

Good

Is the service caring?

Our findings

People told us that staff were caring and considerate. Despite people telling us there were not always sufficient staff to meet their needs in a timely manner they were much more positive about their relationship with and the quality of their interaction with staff. One person who had recently been admitted told us; "No complaints, it is very much as I expected" another person said; "I would like to stay here, it is a remarkable home." One relative who was a very frequent visitor told us; "I feel the care is good". Even when relatives had concerns about staffing numbers, they were often keen to praise the staff themselves; "They are very busy, but also very caring you can't fault them about that."

We observed care throughout the day, including over lunch in different parts of the service. The interactions we saw were positive. We found there was good evidence of caring shown throughout the day by staff. The whole atmosphere of the upstairs Memory Lane unit was very calm, which can be very difficult to maintain in a nursing dementia unit. We saw that when help was needed, staff worked together as a team and one would help another, very often without needing to be asked to do so.

Where people had less positive assessments of the care experience they received or observed, they did not, in general, 'blame' the individual staff members, rather the management and workload. "They do the best they can in the time they have" one person told us. We were made aware of concerns raised with the local authority and the service about poor moving and handling practice, lack of engagement or stimulation observed by a relative. This was being followed up and the registered manager was co-operating fully in this. One person who had raised concerns about their relative's care, principally about staffing levels, nonetheless told us; "So many good things were seen and experienced."

People told us they were able to express their views about their care and support and how it was provided. They and their relatives where relevant, told us they were involved in decisions about their care. They said they felt able to ask questions and express their opinion about their care and to change their routines if they wanted to do so. The care plans we saw had variable levels of detail about the active involvement of people in their care although all had some at least. Overall we found the care plans had improved since the previous inspection although there were still variations in completeness from unit to unit.

The care and support we observed was given with due attention to people's dignity and was provided in a respectful way. When we asked to speak with people, staff first asked them if this was acceptable to them and made sure people were dressed appropriately and were comfortable when we did so in their own rooms.

Staff had received training in end of life care. One person had died two days prior to our visit. When we talked with staff on that unit about this, they confirmed it had been expected. We asked if staff had received any feedback or support and they said no. Staff did not specifically tell us it was required in that case. They were aware of the need to provide care in those situations sensitively and to be responsive to changes in people's needs. This was intended to ensure people's care at the end of their lives was effective and appropriate, including the management of pain.

There was one specific concern raised with the CQC, the service and the local authority safeguarding team about a person's end of life care. The details of this were subject to some difference of opinion. The registered manager and the person who raised concerns were in contact and working together, as far as they were able, to achieve the best possible outcome for the person concerned. This, however, remained a contested situation.

There were details of advocacy services available to people in the home. People had access to advocacy services when they needed them. Advocates are people independent of the service who help people make decisions about their care and promote their rights. This meant people who needed support to express their point of view about their care and support were able to access independent help to achieve this. In most cases we were told, people either self-advocated or family and/or friends advocated on their behalf.

In their PIR the provider confirmed they had equality and diversity policies and procedures in place and staff we spoke with understood the importance of these and how to treat people as individuals irrespective of ethnicity, gender, sexual orientation or their physical or mental ability.

The staff team was not overall representative of the people they provided care and support for. This was not however raised as an issue with CQC by either the people themselves or their relatives, with the exception of difficulty in some cases of understanding staff where English was not their first language.

Requires Improvement

Is the service responsive?

Our findings

To see how people were protected by the service's record-keeping we looked at 15 care plans. On the basis of those care plans we saw, there had been an improvement in the standard of care records since the previous inspection. There was however, still a significant contrast between the best examples seen and those with gaps or where the information was not always up to date. The recent significant changes in the staffing of the service and the introduction of new staff which was underway, may have contributed to this inconsistency.

We again received feedback following the inspection from health and social professionals who were involved with the service which also raised concerns over the consistency of care plans. An action plan was in place, following an inter-agency safeguarding meeting held in March 2016, which included record keeping as an agreed area for improvement. The registered manager was co-operating fully in that process.

We recommend the registered manager reviews care plans with senior staff to ensure these are consistently well-completed and include readily accessible details of people's life histories to inform how their care is provided.

Where care plans were fully completed we found they gave the information care and nursing staff required to provide care and treatment focussed on the individual and taking their wishes and preferences into account. This included, mental capacity assessments, advanced care plans, and in most cases past medical history and allergies. In general, risk assessments and their reviews had been completed and undertaken.

In some cases we found the 'life history' of people who received care was not always readily accessible. In some cases this was because people or their relatives had not provided it, in others it was not very detailed and in others we found it difficult to locate, even when it had been completed. This made it harder for staff to reflect the individual's past history, interests and wishes in the practical, day to day provision of their care. We also found on Memory Lane, that not all rooms had 'memory boxes' to help people and staff provide care that reflected people's past lives and interests. However, we also found that established staff knew the way people liked their care provided and sought to meet their wishes. When we spoke with them, they could explain what their care needs were and how they were meeting them.

One very positive feature of the inspection was the active involvement of support staff in the life of people who received care. For example, administrative, maintenance, hospitality and activities staff provided support to care staff and interacted very positively with people who lived in Chalfont Lodge. One particularly striking example of this was a member of the house-keeping team who was exuberant and cheerful in their interaction with people whose rooms they were cleaning and who noticeably raised a smile and response from them.

We spoke with an activities co-ordinator. They provided details of a typical activity programme and some of the events that had taken place. People we spoke with were quite positive about the activities and we observed activity sessions, including external 'entertainers' during our visit.

We also spoke with the service's music therapist who we saw working with people on the first floor. They were responding very positively and nursing and care staff were also helping and encouraged people, who were said usually to be quite 'withdrawn' to join in.

We were shown the physiotherapy room where we were told physiotherapy is provided every week by a qualified physiotherapist and two physiotherapy assistants.

There was evidence during our visits and from significant contact with relatives before and after them of visitors coming to the service and of people going out for trips with their families and friends. There was a suggestion made by some relatives that the activities arranged for people outside the service had been reduced. We understood this was in part a seasonal issue and that external activities would continue with appropriate staff support.

People had access to health services as they needed them. Care plans included details of hospital and community health appointments as well as those which took place within the service. For example, we found evidence in care plans that referrals had been made to speech and language services, physiotherapists, opticians and dentists. A GP from the practice associated with Chalfont Lodge carried out 'surgeries' every Monday and Friday and a nurse from the same practice was in the home every Wednesday.

We received feedback from a specialist community health practice. They were very positive about the facilitation of their visits by Chalfont Lodge and the involvement of their staff. They told us records were "always available and up to date." They assessed that there was a clear focus on patient safety and risk assessment.

They did note that at weekends there appeared to be fewer staff and that some people appeared isolated. One area where they thought improvements could be made was in having some way of informing people who was on duty, who were people's key workers and who was in charge of the unit on that day. They also thought the system for communicating with families and professionals about significant events such as GP appointments, medicines changes or significant incidents could be improved. They said, however, that staff were very forthcoming when approached for information during their visits. They also stated that Chalfont Lodge showed great respect for each person's privacy and dignity and individuality. They paid particular tribute to the activities staff and assessed that; "The range of activities, group and individual, events and social interaction is excellent and very beneficial to patients."

Systems were in place to manage complaints and concerns. We were included before, during and after the inspection in e-mail correspondence between relatives and the home's manager. There was a formal complaints procedure clearly available within the home, which included contact details for the CQC and other appropriate bodies. Complaints were recorded and the outcomes noted. The majority of people or relatives we spoke with indicated they would approach staff and the management of the service informally in most cases rather than raise an official complaint.

It was noticeable, that people who raised complaints and concerns with CQC about Chalfont Lodge were in most cases positive about the response of and their interaction with the registered manager, even when they were critical of some of the care provision or specific failures of care as they saw it.

Requires Improvement

Is the service well-led?

Our findings

People were in general positive about the local management of the service. Staff we spoke with confirmed the recent more stable management position had been positive for continuity and consistency. The appointment of a new deputy manager was welcomed although they had not taken up their post at the time of our inspection.

During the inspection, prior to as well as following our visits, we received very full and effective co-operation from the registered manager and the regional director. They displayed openness and candour in terms of the information provided to CQC and during discussions with them about the inspection and future plans for the service.

Providers and registered managers are required to notify us of certain incidents which have occurred during, or as a result of, the provision of care and support to people. The registered manager had submitted appropriate notifications about significant events affecting the service.

Throughout the inspection process we found evidence the recent significant turnover in staff, including some at management level, had been challenging. We again received different assessments of the service from agencies working with them. The consistency of records and staffing levels being common concerns. There was a considerable degree of support for the management of the service, although the pace and consistency of improvements was a concern for some people and agencies.

Staff confirmed they had meetings with managers at all levels and that the registered manager was visible throughout the service on a daily basis. There were daily meetings with the heads of department and the registered manager. In addition, the registered manager carried out and recorded a daily management report including checking documentation, staffing and the home's environment. There were also reports of night visits and shift handover sheets for each unit.

There was a quarterly manager's quality assurance tool which was in place which comprehensively captured all areas of the homes operation in detail. These measures and systems confirmed the operation of all areas of the home's activity were being effectively monitored.

We saw minutes of relatives'/residents' meetings held in January 2016, we were also told of meetings planned for April 2016. These minutes included action plans to address any issues raised and meant that people who used the service and those people responsible for them were able to raise any issues or concerns and to make suggestions or comments about their experience of the service and the way it operated. The concerns noted within this report had all featured in these meetings. For example, the operation of the key worker role, staffing at weekends and care shortfalls associated with availability of staff at times were all raised.

The service maintained good links with the local community and voluntary groups who visited the home, for example schools and churches.

The rating of requires improvement reflects the concerns raised in this report and from external partners which have previously been noted, for example in the last report by CQC and which have not yet been fully addressed.

The helpful input of the registered manager to the inspection process is acknowledged as is the positive assessment of their contribution to the service's operation made by a number of people who we received feedback from.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not always effectively deployed to meet the needs of people using the service at all times.