Prime Life Limited

# Chestnut House

## Inspection report

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21 May 2018

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

We undertook a comprehensive inspection on 18 and 21 May 2018. The inspection was unannounced.

Chestnut 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.

Chestnut House is registered to provide accommodation for up to 33 people living with a mental health problem or younger adults. The service can accommodate 19 people in the main house and a further 14 people in seven self-contained flats. During our inspection there were 32 people living in the service. Seven people were living in the service under a tenancy agreement and did not receive personal care from the provider. We have not referred to these people in our inspection report.

There was a registered manager in post at the time of our inspection. 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 the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We last inspected the service in November 2016. The service was rated requires improvement.

Staff were aware of how to keep people safe from the risk of harm and abuse. People had their medicines administered safely by trained and competent staff.

Quality monitoring systems were in place. However, these did not identify weaknesses in the standards of cleanliness in some areas of the service. People were not always provided with a balanced and nutritious diet or involved in planning their menus.

People had their care needs assessed and their care was planned in line with up to date guidance and legislation. There were sufficient staff to care for a person's individual needs and staff were trained appropriately.

People were cared for by kind, caring and compassionate staff. People and staff had a good relationship and the service had a family atmosphere. People were cared for as unique individuals and their privacy and dignity were respected.

Staff supported people to spend their time as they wished and people frequently went on shopping trips to a nearby town.

People spoke highly of the care they received and the attitude of staff. Staff enjoyed working at the service and were proud of their achievements. The registered manager was proactive and had introduced

improvements to the service.

People who live in the service and staff have a voice and are supported to give their feedback on the service.

This is the second consecutive time the service has been rated Requires Improvement.

## 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 always safe.

Some areas of the service fell below acceptable infection control standards.

A robust approach to risk assessments had been introduced to protect people from the risk of harm and accidents.

People received their medicines from staff that were competent to do so.

When things went wrong the provider took appropriate steps to put them right.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

People were not always provided with a nutritious and balanced diet.

People were cared for by staff who had the knowledge and skills to support their needs.

Staff understood the principles of the Mental Capacity Act 2005 and sought consent from people in line with current legislation.

### Is the service caring?

**Good**

The service was caring.

People were looked after by kind, caring and compassionate staff.

Staff treated people with dignity and respect and protected them from direct discrimination.

### Is the service responsive?

**Good**

The service was responsive.

People had their care needs assessed and were treated as unique individuals.

People found the staff and registered manager approachable and knew how to raise a concern.

Staff supported people to maintain their religious, cultural and spiritual beliefs.

## Is the service well-led?

**Requires Improvement** 

The service was not always well led.

Quality monitoring processes did not always identify failings in the service.

Staff had access to policies and procedures supported national guidance.

The registered manager had a vision to introduce and sustain improvements to the service.

# Chestnut House

**Detailed findings**

## Background to this inspection

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

This inspection took place on 18 and 21 May 2018 and was unannounced. The inspection team consisted of one inspector, an assistant inspector, a specialist advisor 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. 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 took this into account when we inspected the service and made judgements in this report.

Before the inspection we reviewed any information we held about the service. We reviewed safeguarding alerts and notifications that had been sent to us. A notification is information about important events which the provider is required to send us by law.

During our inspection we spoke with the registered manager, a managing director, five members of care staff, and nine people who lived at the service. We also observed staff interacting with people in communal areas, providing care and support.

We looked at a range of records related to the running of and the quality of the service. These included three staff recruitment and induction files, staff training information and arrangements for managing complaints. We looked at the quality assurance audits that the registered manager and the provider completed. We also looked at care plans for eight people and medicine administration records for 25 people.

Following our inspection, the registered manager provided us with information on progress made since our inspection. We also received feedback from healthcare professionals involved in the care of people living in

the service.

Requires Improvement

# Is the service safe?

## Our findings

All staff had attended infection control and safe food hygiene training, had access to policies and procedures that reflected national guidelines and had access to personal protective equipment. We were told that the standards of cleanliness in the home were regularly assessed by the registered manager. However, we saw that good infection control practices were not always adhered to and people were at risk of food poisoning from out of date food and cross contamination from an unclean kitchen. We shared our concerns with the registered manager and managing director.

On day two of our inspection we observed a member of staff prepare a variety of sandwiches for tea time. We noted that the cold meat being used was out of date. We brought this to the attention of the member of staff who continued to use it as a sandwich filler. We noted that there were several packs of out of date cold meat stored in the fridge. Records showed that the member of staff involved had completed food hygiene training in December 2017. A member of staff went to the local shop to purchase fresh cold meats and bread for the sandwiches. Therefore people were no longer at immediate risk of harm from out of date food.

The toilet adjacent to the satellite kitchen was dirty, there were no hand washing facilities and there was an offensive odour and urine on the floor. We brought this to the registered manager's attention. Since our inspection the toilet has been refurbished with a new wash hand basin and lavatory. The satellite kitchen was intended for use by people who lived in the service. We found that it was not fit for purpose. The seal around the work surface was damaged, the microwave was dirty, cutlery was stained and kitchen units were damaged. Furthermore, we saw that the toaster, kettle and microwave were stored under wall units. The wall units were damaged by heat and steam. This put people and staff who used the kitchen at risk of avoidable harm. We brought this to the registered manager's attention. Since our inspection the registered manager has provided us with photographic evidence that the satellite kitchen had been upgraded and the risk of harm from the environment has been assessed as low.

The registered manager had nominated a member of staff as the infection control lead who attended the local authority infection prevention control (IPC) forum led by the local authority IPC team. Their knowledge gained was shared with other staff at team meetings. Following the improvements made to food preparation, safe food storage practices and the upgrade to the satellite kitchen the service received a five-star food hygiene rating from the local environmental health authority.

The registered manager and managing director's positive and timely response to our concerns demonstrates that lessons had been learned and improvements made when things go wrong.

People who lived in Chestnut House told us that it was a safe place to live. One person told us, "I do feel safe here." Another person said, "Staff are good at keeping us safe." The provider had a confidential 24-hour helpline that staff, people who lived in the service, their relatives and professional visitors could access if they wished to raise a safeguarding or whistleblowing concern. We noted that information leaflets on this facility were available throughout the service. Care staff told us that they would not hesitate to report concerns if they felt that a person was at risk of harm.

We saw that the provider had up to date certificates to confirm that essential safety checks had been carried out to keep people safe.  For example, electrical appliance testing, fire safety and water safety. People and staff were aware of the action to take in the event of a fire or other emergency and people had individual personal emergency evacuation plans in place with their photograph for identification purposes.

People had their risk of harm assessed for the internal environment, their care needs and accessing the community. We saw that appropriate action was taken when a risk was identified. For example, one person liked to go for walks at night. To ensure they were safe from passing traffic they were provided with, and wore a high visibility vest and reflective arm bands.

A robust recruitment and selection process was in place and staff had been subject to criminal record checks before starting work at the service. These checks are carried out by the Disclosure and Barring Service (DBS) and helps employers to make safer recruitment decisions and prevent unsuitable staff being employed.

The number and skill mix of staff on duty varied from day to day depending on what activities and pastimes people were taking part in and how much support they needed. Bank staff were employed by the provider to cover unfilled shifts in any of their services. People told us that they knew the staff who cared for them and that there was always enough staff on duty.

The dispensing pharmacy had recently introduced a new method of administering medicines. Each individual medicine was dispensed in a bio-pod with the name and dose of the medicine, the person's name, date of birth and their photograph on it. Staff did not undertake a traditional ritualistic medicine round. Instead, individual people attended the medical room at the time their medicines were due and staff administered them in privacy. We found that this change to dispensing and administration practice reduced the risk of interruptions and errors. One person said that they liked the new arrangements for receiving their medicines and said, "I feel I can speak to the senior in confidence when my medicines are administered."

Some people administered their own medicines. We saw that risk assessments were in place and people had a lockable space to keep them safe.

Requires Improvement

# Is the service effective?

## Our findings

We observed that mealtimes were a social event and several people pulled together to set the tables, assisted with serving and helped clear away and wash up. Some people preferred to eat their meals on their own and staff respected their preference to eat in their bedroom or flat. There was a full time cook employed at the service. When they were off duty, care staff prepared and cooked the meals. Some people were offered a choice of meal to suit their needs and dietary preferences. For example, we saw that vegetarian options were available. However, when we looked at the food intake records for a person with swallowing difficulties, we saw that they were not provided with the pureed diet prescribed by the speech and language therapist. Instead they had porridge at breakfast and soup for lunch and tea every day. We shared our findings with the registered manager who said that they would discuss the person's nutritional needs and preferences with the person and the cook, to provide them with a varied and balanced diet.

There were no menu plans in place or records of individual food likes and dislikes. The daily meals were planned without input from the people who would eat them. We looked at previous menu records maintained by the cook. We noted that the meals were repetitive, relied on frozen and convenience foods and not always nutritious. For example, pasties, sausage rolls and burgers. We found little evidence of fresh produce and home cooked meals. Overall, people were not offered a nutritious and balanced diet.

Since our inspection the registered manager has informed us that they now purchase fresh locally sourced produce and people are provided with a nutritious and balance diet. People have also been involved in developing a menu plan that reflects their food preferences.

People had their needs and preferences assessed and we found that care and support were given in line with national guidance and evidence based practice. Staff received training relevant to the needs of the people in their care. For example, dignity, consent and health and safety.

New staff undertook a period of induction and shadowed experienced staff. A recently appointed member of staff said, "I shadowed shifts over three days. It was a very good way of being introduced to residents as a new member of staff." A member of bank staff told us that they had received an induction and accessed the same training as permanent staff.

We saw that staff received regular supervision sessions and had an annual appraisal. We looked at supervision and appraisal records and noted that staff were provided with feedback on their performance and identified their training and development needs. A member of staff told us, "[Registered manager] told me I was a trusted and valued member of staff. That meant a lot to me." People were cared for by staff whose professional development was supported to by the provider.

Staff ensured that essential information was shared when a person was admitted to hospital. People had a grab sheet that provided essential information about an individual, including their likes and dislikes, medication and health history. Some people with limited communication had a communication passport with all the information a future health or social care professional would need to effectively deliver their care

needs.

Staff supported people to access their healthcare professionals, such as their GP, dentist and community psychiatric team. On day one of our inspection several people had appointments at their local medical practice. One member of staff was allocated to take them there by car and support them both physically and emotionally.

We saw that good practice guidelines were followed when staff identified that a person had a health issue. For example, one person was seen by their GP following a fall and they were diagnosed and treated for a heart problem. This demonstrated that people received prompt referral, diagnosis and treatment.

Since the appointment of the registered manager in 2017 areas for improvement in the service had been identified and actioned. For example, bathroom units, new beds and bedding had been purchased. Some people showed us their bedrooms and they had recently been decorated. People told us that they had chosen their own decoration. In addition, new laundry and clinical rooms had been introduced. The laundry room was spacious and where able, people were supported to wash and iron their own clothes.

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. Staff understood the principles of MCA and acted in accordance with the law and sought consent from people for aspects of their care.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Three people living in the service at the time of our inspection were subject to a DoLS authorisation.

When a person was unable to make an important decision for themselves, they were supported by an independent advocate to speak on their behalf.  However, no one currently required the support of an advocate. We noted that some people who lacked capacity to look after their own finances had a deputy appointed by the court of Protection to look after them on their behalf.

Good

# Is the service caring?

## Our findings

People told us that they were cared for by kind and caring staff. One person shared their thoughts and said, "They are really caring staff. That's what I like about it; that they actually authentically care about you and go out of their way a lot and are generous caring people."
We observed that staff had a caring approach towards people and treated them with kindness and compassion. For example, we witnessed a situation where a person who lived in the service was becoming angry and challenging. The registered manager sat with the person and calmly reasoned with them. The person soon settled and a potentially volatile situation was avoided.

People were enabled to express their views and be actively involved in decisions about their care. They were included in their risk assessments and planning their care with their key worker. One person said, "[Name of key worker] does my care plans for me. I'm involved in that."

People had a say in the running of the service and were invited to attend regular resident meetings. We looked at the minutes from the meetings held in February and April 2018 and saw that suggestions made were actioned. For example, changes to the menu and the installation of a new pay-phone. One person told us that they felt involved in the running of the service and said, "I attend and contribute to the residents' meetings and I can contact the manager at any time." Other people spoke about the calm and relaxed environment within the service and how it made them feel part of a family. We received comments such as, "We all get on well. [Registered manager] is a great boss and it's like a family. [Registered manager] doesn't make odd rules up. It's easy to live with a boss who makes me feel better anyway." and "It's relaxed here and that is good. It's the best place I've been to." We noted that the minutes of the residents' meetings were produced in written and easy-read format, therefore they were accessible to people with varied reading abilities.

Several people had their own mobile phone or laptop and were able to maintain contact with family and friends through various forms of social media whenever they wanted to. People told us that their friends and family could visit at any time and their privacy was respected. One person said, "We can go in the Sky Room (a quiet lounge) if we want, or we can meet in my bedroom."

We noted that the provider was committed to treating people with dignity and respect. Staff had access to guidance on how to protect people from direct discrimination and promote their equal rights. People told us that they were treated as unique individuals.

People were given the choice to have a key to lock their bedroom or flat door. People told us that they were not discriminated against by staff or other people who lived in the service.

Good

# Is the service responsive?

## Our findings

People had their care needs assessed and personalised care plans were introduced to outline the care they received. We saw that individual care plans focussed on supporting people to live well and maintain their optimum level of independence and well-being. Staff exchanged information about a person's care needs and wellbeing at shift handover to maintain continuity of person- centred care.

People were supported to develop and maintain their individual interests and hobbies, paid and voluntary work and access to education programmes. We spoke with one person who had recently achieved an academic certificate at a local further education college and also attended art classes in the village. They proudly showed us some of their art work. This person also led a relaxation and beauty therapy class for their peers once a week. We found that this was well supported.

People are encouraged to make decisions about how to spend their time. For example, care staff supported people to access a community transport scheme. This enabled people to maintain links with the local community and visit nearby towns independently to meet up with friends and do personal shopping. Some people told us that they did not need to go out often and one person explained, "I go out sometimes to get a drink and go to [Name of supermarket], all my friends are here though, so I don't need to go out." We also found that people planned group outings once a month. Popular destinations included nearby seaside resorts.

People were supported to maintain their religious, cultural and spiritual beliefs. For example, one person had joined a church in a nearby town. This had been beneficial to the person as they had made new friends and their confidence in their own ability had improved. Another person had a personal crisis and asked care staff to pray with them until specialist help arrived from the community mental health team. A staff member said, "I sat and prayed with them. It really worked and helped calm them down."

People were aware of the complaints procedure and told us that they would not hesitate to speak with the registered manager or their key worker if they had a concern. However, we saw that no formal complaints had been logged since our previous inspection.

On day one of our inspection people were looking forward to a street party for a royal event. However, when we returned on day two we were informed that one person had died unexpectedly. This had an emotional impact on the people who lived in the service and staff. Therefore, they had mutually agreed to cancel their street party as an act of respect for their friend. The registered manager explained that the service did not experience many deaths and people needed time and support to cope with their loss.

We saw the care plan for one person had a GP letter stating that the person was near the end of their life. However, the person did not have an end of life care plan and there was no recorded evidence that staff had discussed their wishes with them. The registered manager contacted the person's community nurse and GP to develop an end of life care plan with the person that addressed their needs and wishes.

Requires Improvement

# Is the service well-led?

## Our findings

A programme of regular audit was in place that covered key areas such as health and safety, medicines and infection control. Action plans with realistic time scales were produced to address any areas in need of improvement. The audit outcomes and required actions were shared with staff at team meetings and daily handovers. In addition, the registered manager undertook an annual quality assurance audit on behalf of the provider that covered all aspects of standards of care in the service. This was also produced in an easy-read format. Staff had access to up to date policies and procedures, that were supported by national guidelines. Feedback from quality reviews and changes to policy were shared with staff at team meetings and handover.

However, despite an improved quality governance approach taken by the recently appointed registered manager, the current audit system did not identify the weaknesses we found with safe infection control practices and nutritional support.

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.

Staff spoke positively about the leadership in the service and told us that it was a good place to work. One staff member who had worked at the service for several years spoke of the positive impact the new registered manager had on the service and said, "It's a very well run home now. [Registered manager] is very supportive, approachable and easy to talk to." Likewise, the people we spoke with said that they could speak to the registered manager or their key worker about anything at any time. We noted that throughout our inspection visit people would seek the registered manager for advice, a chat or just to say hello.

The registered manager submitted notifications of events that happened in the service that they are required by law to tell us about. We also saw that the rating from the last inspection was on display and accessible on the provider's website.

The registered manager had shared their vision for improvements to the service with people who lived there and staff. Staff told us that care practice had recently changed for the better and they had an improved understanding of what was expected of them. Staff attended regular team meetings, had a voice and told us that they were listened to.

Staff had access to policies and procedures that reflected current best practice guidance. In addition, the service subscribed to regular updates from national organisations, such as National Institute for Clinical Excellence, Skills for Care, NHS Patient Safety Alerts and Social Care Institute for Excellence. The registered manager participated in local authority coordinated learning and development events. The regional director visited the service at least once a week. The registered manager informed us that they could share any concerns they had about operational issues and the quality of the service with them and they were

supported to make and sustain change. Overall, the registered manager and staff had access to resources to keep them up to date with good practice.

The registered manager has improved links within the local community and was continuing to build on these. People were supported to access the local shops, public house and college. People told us that they liked the village that they lived in and felt that they belonged there.