Maria Mallaband 13 Limited

Chaucer House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 23 and 24 November 2017 and was unannounced.

Chaucer House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during the inspection.

Chaucer House is registered to accommodate up to 60 people. At the time of the inspection there were 41 people living at the service.

We carried out a comprehensive inspection on 19 and 21 September 2016 and the service was rated Outstanding. This inspection was prompted by information from the local authority, other healthcare professionals and relatives that there were increased risks to people's safety, health and welfare following the registered manager leaving. This inspection examined those risks.

There had been a change in the management of the service since our last inspection. There was a registered manager leading 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. The registered manager had started working at the service in August 2017.

There were not sufficient staff on duty to provide consistently safe, effective and person centred care. There had been a reliance on high levels of agency nursing and care staff; however, at the time of the inspection, the amount of agency staff had reduced. Staff did not always have the skills to provide the care and support people needed. Staff had not received consistent supervision and appraisal. The registered manager had increased the number of staff on duty, following the inspection; they told us that another member of staff would be on duty during the day. We will check this at our next inspection. Staff were recruited safely. New staff completed an induction when they started work at the service.

Potential risks to people's health and safety had not been consistently assessed and there was not always detailed guidance for staff to following to mitigate risk. The high use of agency staff meant that people were at risk of not receiving safe care. During the inspection, we observed staff and staff told us how they supported people safely.

Checks to the environment and equipment were completed to ensure they were safe. Shortfalls were identified, however, action to mitigate risk to people's safety was not always taken quickly.

Before the inspection, concerns were raised about unsafe management of medicines. The registered manager had taken action to reduce medicines incidents, these had been effective. During the inspection,

medicines were being managed safely.

Each person had a care plan. The care plans contained information about people's lives before they came to live at Chaucer House. However, the care plans did not consistently contain details about people's care and support that was unique to them. During the inspection, we observed and staff told us about people's preferences and how they provided person centred care. People were assessed before coming to Chaucer House. The registered manager assessed the person's mental health, physical and social needs, including equality and diversity but this had not always been reflect in the person's care plan.

Some people were receiving end of life care. There were not always enough staff to provide the skilled care and support to the person and their family. There were not detailed care plans in place to guide staff about the person's wishes and the support required.

People and relatives told us, that staff were kind and caring. However, they told us that staff did not always maintain their dignity and treat them with respect, they felt this was due to not having sufficient numbers of staff on duty.

Audits had been completed, shortfalls had been identified but sufficient action had not been taken to rectify the issues and the same shortfalls were found at this inspection. There were systems in place to receive feedback from people, relatives and staff. Complaints had been received from relatives, but action had not always been taken to improve the service. There was an action plan in place, the registered manager, had started to complete actions required.

The building was purpose built, meeting people's physical needs. However, in the dementia unit the signs to direct people to places such as the bathroom, were not clear and were not pictorial. There was a risk that people would not be able to find their way around the unit. This was an area for improvement.

People and staff had the opportunity to attend meetings. Staff meetings had not been held regularly, the registered manager had identified this and meetings were held regularly, to keep staff up to date and receive their feedback. . A relatives meeting had been held in May 2017, but there were no minutes available. There were activities available each day.

Staff knew how to recognise signs of discrimination and abuse. They were confident that any concerns would be dealt with appropriately. The registered manager had reported incidents to the local safeguarding team when appropriate and was working with healthcare professionals to reduce the risks of the incidents happening again.

People were supported to eat and drink enough to maintain a balanced diet. Staff referred people to specialist healthcare professionals such as dieticians when required and followed the advice given. People had access to opticians and chiropodists as needed. People were protected by the prevention and control of infection procedures.

People were supported to have maximum choice and control of their lives and staff supported them in least restrictive way; policies and systems in the service supported this practice. Staff were kind and compassionate when spending time with people, they supported people to make choices about their care and support where possible.

Staff told us that they felt supported by the registered manager and felt that the service had started to improve. The registered manager promoted an open culture within the service, they were visible around the

service. There were mixed views from people and relatives, some people knew the registered manager and others stated they had not met them. The registered manager told us that they were trying to meet as many people as possible.

The registered manager was aware of the shortfalls in the service and was working through an action plan to rectify these. They had worked with other agencies and healthcare professionals to build relationships to reduce the risk of incidents in the future.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. CQC check that appropriate action had been taken. The registered manager had submitted notifications in an appropriate and timely manner and in line with guidance.

Providers are required by law, to display their CQC rating to inform the public on how they are performing. We found that the provider had conspicuously displayed their rating at the service and on their website.

At this inspection five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. You can see what action we have asked the provider to take at the end of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were not sufficient staff on duty to meet people's needs.

Potential risks to people's health had not been consistently assessed; there was no detailed guidance for staff to refer to.

Action had not been taken to mitigate risks to people associated with the building. The service was not consistently clean.

People's medicines were being managed safely.

Staff knew how to recognise and report abuse. The registered manager had made improvements following incidents and accidents.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received specialist training to meet the needs of people living at the service.

Staff had not received consistent supervision and appraisal.

People's needs were assessed, but were not always reflected in the care plan.

The building met people's physical needs, however, the signs in the dementia unit were not clear for people to understand.

People were supported to eat and drink enough to maintain a balanced diet.

Staff monitored people's health and worked with other health professionals to meet their needs. People had access to healthcare services and support.

The registered manager worked with other agencies to improve the care and support people received.

Staff worked within the principles of the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and respect as there were not sufficient staff on duty.

Staff were kind and compassionate when they were with people.

Staff encouraged people to express their views and be involved in decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People received personalised care, however, the records did not reflect the care being given.

There were activities available .

People knew how to complain but were not confident that they were listened to. Complaints received did not have detailed information of how they were investigated and the action taken.

People who required end of life care did not have care plans in place to support them and their families.

Is the service well-led?

Requires Improvement

The service was not always well led.

Audits and checks had been completed and shortfalls were identified, however, action was not taken quickly to rectify the shortfalls and improve the service.

Staff told us that the registered manager was supportive and making improvements to the service.

People, relatives and staff were asked to give feedback about the service.

The registered manager promoted an open and transparent culture. They worked with other agencies to improve the service.

Notifications were submitted in line with best guidance.

Chaucer 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 checked 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.

The inspection was prompted by notifications from the local authority and healthcare professionals about incidents that were being investigated. The information shared with CQC indicated potential concerns about staffing and increased risks to people's safety, health and welfare. This inspection examined those risks.

The inspection took place on 23 and 24 November 2017 and was unannounced.

The inspection team consisted of two inspectors, a nurse specialist 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 service.

The inspection was completed in response to risk; the provider was not able to complete a 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 reviewed information received from 'share your experience' forms that were sent to us from people telling us about poor care being provided. We considered information from a number of professionals about incidents that had occurred within the service. We reviewed notifications we had received from the service. Notifications are information we receive from the service when significant events happen, like serious injury.

During our inspection we spoke with 11 people living at the service and ten relatives. We spoke with the registered manager, quality manager, administrator, three nurses, five care staff, maintenance man, chef and housekeeper.

We looked around areas of the service. We did not use the Short Observational Framework for Inspection (SOFI) as people were mainly in their rooms. SOFI is a way of observing care to help us understand the

experience of people who cannot talk to us in communal settings.

We reviewed records including nine care plans and risk assessments. We looked at a range of other records, staff rotas, medicines records and quality assurance surveys and audits.

We last inspected Chaucer House in September 2016 and the service was rated Outstanding overall.

Requires Improvement

Is the service safe?

Our findings

People and relatives told us that there were not enough staff to meet people's needs and keep them safe.

Relatives, staff and visiting professionals had raised concerns about staffing levels and the impact this was having on the safety of people living at the service. One relative told us, "They are always pushed and if we need them to do something, it takes forever." Another relative told us, "I come in most days. I do not think that my loved one would be receiving good care if they just relied on the staff."

Since the last inspection, a number of qualified nurses and care staff had left, and there had been a high reliance on agency staff. The registered manager told us that there had been a recruitment drive and new staff had been employed recently and the use of agency staff had lessened.

During the inspection there were four care staff on each floor with a registered nurse. The registered manager told us that they had increased the staffing to four care staff on each floor recently. There was an agency member of staff and a member of staff had been called in to cover sickness. People living at Chaucer House were highly dependent on staff to support them with all their needs. During the morning we did not see staff in the main lounges, staff did not finish supporting people with their personal care until lunchtime.

People told us and we observed, people having to wait for over 15 minutes for their bell to be answered, then the bell was not answered by care staff. The staff member who answered the bell had to go and find a member of care staff to support the person, causing further delay. Some people required support to walk to the bathroom, they told us that waiting for long periods for support, had caused them to be incontinent, causing them distress.

Before the inspection, concerns had been raised by relatives and professionals, that people were not receiving their medicines as prescribed. The use of agency nurses, who were not confident with the systems and people, meant that people had not received medicines when they needed it including antibiotics. For example, antibiotics were not given to one person as the agency nurse did not know how to record the antibiotics on the electronic system.

One healthcare professional we spoke to told us that staff found it difficult to give the required support to people who had complex needs, due to staffing levels. There was one nurse on duty at night for the service, this was often an agency nurse. Relatives told us that their loved ones had to wait for the nurse at night, especially if there were was more than one person requiring the nurse's support. One relative told us they stayed with their loved one during the night as they were not confident that their loved one would receive the care they needed.

The provider had failed to have sufficient numbers of competent, skilled and experienced persons deployed in order to meet people's needs. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that there had been staffing difficulties but the new registered manager had employed staff and that the situation was improving. The registered manager completed a tool which included the number hours budgeted for and the number of additional care hours. This information was sent to head office who determined whether the service had the correct number of staff. Following the inspection, the registered manager told us that it had been agreed that an additional member would be on duty during the day.

Potential risks to people's health and welfare had not been assessed consistently and there was not always clear guidance for staff to mitigate the risk. Some people required support to move safely. Assessments had been completed and the outcome of these had been recorded. The assessments had not included all areas relating to people's support needs. For example, if the person was able to move themselves while they were in bed. There was no guidance for staff about how to support people to move in bed including what equipment was needed. Staff were given guidance about the hoist and sling to be used but not how the sling should be positioned or how to support people if they had specific needs. For example, one person may become rigid at times and staff should be aware of this, however, there was no guidance about how to move and support the person if they became rigid. Staff told us how they moved the person safely.

Some people had difficulties with their swallow and required all food and drink to be a special consistency. There were guidelines for staff about how to prepare the food and drink including the support needed. However, one care plan stated the person was at risk of choking and the person had been diagnosed, previously, with pneumonia caused by food and drink not being swallowed correctly. There was no risk assessment to give guidance to staff about how to mitigate the risk of aspiration and what to do if the person did choke. Staff were able to describe how they supported people, what signs they would be looking for and what action they would take if someone choked. However, there was a risk that new and agency staff would not have sufficient guidance to give safe effective care.

Regular checks were completed on the environment and equipment to ensure they were safe. Environmental risk assessments had been completed, however, not all shortfalls identified had been rectified or a risk assessment put in place to mitigate risk. For example, whilst completing a walk round the service, several doors to people's rooms were propped open with objects such as footstools. This meant that if the fire alarm was activated the doors would not close automatically. The registered manager told us that there was an ongoing problem with the automatic door closers on a couple of doors. The issue had been highlighted in the provider's action plan in June 2017, the contractor had visited the service but the problem had not been solved. There was no risk assessment in place to guide staff about which doors were affected and what action to take in a fire. During the inspection, the registered manager checked how many doors were affected. There were 11 doors that were propped open. The registered manager put a risk assessment in place and had put notices at the nurses' station telling staff which doors were affected and what to do in the case of a fire. The quality compliance inspector told us that they would be contacting the contractor urgently.

The provider had failed to assess the risks to the safety of people receiving care and treatment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The building was not consistently clean and hygienic. Some relatives told us they did not think that the standard of cleaning was satisfactory. In one communal lounge there was a smell of urine, staff told us that the lounge had been deep cleaned that week and the sofa removed, because of the smell and the lounge would continue to be cleaned. There were sufficient domestic staff to keep the building clean, staff followed cleaning schedules to ensure all areas of the service were cleaned regularly.

Staff wore protective clothing such as gloves and aprons when required and followed infection control

policies when dealing with infected laundry.

Before the inspection, concerns were raised by healthcare professionals that medicines were not being managed safely and people were not receiving their medicines as prescribed. The registered manager, had identified the system to supply people's medicines was leading to a number of mistakes by nursing staff and agency staff. The registered manager had changed the supply system to Monitor Dosage System (MDS). This meant that people's medicines were dispensed in blister packs; this was a system that nurses were more familiar with and was easier to check and audit.

During the inspection, the morning medicines round was long and the 08.00am medicine round did not finish until 10.30am, nurses told us that this restricts the time they can spend completing other aspects of their role such as wound care. The registered manager told us that they were developing senior care staff to support nurses with medicines to reduce the length of the medicines rounds. We will check this on our next inspection.

Since the introduction of the new system there had been no medicines errors. There were policies and procedures in place to make sure that people received their medicines safely. Medicines were stored securely. Temperature checks were completed daily to ensure that medicines remained effective. The medicines were administered as instructed by the person's doctor.

Some medicines requiring special storage and monitoring were handled and stored in line with legal requirements. Some people were prescribed medicines on a 'when required basis,' for example, pain relief. There was written guidance for staff about when and what dosage to give people. People's medicines were kept in a locked box in their rooms, we observed a medicines round, people received their medicines safely.

Staff knew how to recognise signs of abuse and discrimination. Staff knew what to do if they suspected incidents of abuse. Staff told us that they felt confident that any concerns they raised would be dealt with immediately by the registered manager. People were protected from the risks of financial abuse, any monies kept for people was recorded along with any purchases and receipts. The registered manager had referred incidents to the local safeguarding authority when needed and co-operated in investigations to learn from incidents to ensure they do not happen again.

The registered manager told us that they had analysed incidents that had happened before they started at the service, to see if there were changes that could be made. The registered manager had made changes within the service. These included changes to the way medicines were supplied, identifying senior care staff to attend additional training to support nurses and meetings at 10.30am of heads of departments to know if there are any issues that need to be addressed.

Staff had been recruited safely. Recruitment checks had been completed to make sure staff were honest, reliable and trustworthy to work with people. This included a full employment history and written references. Each person had proof of identity on file with a photo. Disclosure and Barring Service (DBS) criminal records checks were completed before working at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use services. Checks had been carried out to ensure nurses were registered with their professional body and able to work as registered nurses.

Requires Improvement

Is the service effective?

Our findings

Before the inspection, concerns had been raised by healthcare professionals that staff did not have the skills to give people safe and effective care when they needed it. Staff had received essential training such as moving and handling, safeguarding and infection control, however, nurses had not received specialist training to support people with complex needs.

Some people required end of life care, this may involve the use of a syringe driver. A syringe driver is used to give a constant supply of medicines via injection, to keep people comfortable. There was only one nurse who was trained to set up a syringe driver but had not been assessed as competent. When someone had been prescribed medicines through a syringe driver, the district nurse had been called to assist; the district nurse had not been able to attend for four hours. The person did receive medicines while waiting for the syringe driver.

Following training, staff competency had not been checked. Staff files showed that there was documentation available but this had not been completed. Staff we observed during the inspection were safe when completing essential care. The registered manager had recently started to complete 'being in charge of a shift' competencies for all nurses.

Staff had not been receiving supervision and appraisals to discuss their performance and training needs. Staff had not received any supervision before September 2017 when the new registered manager began working at the service. Staff told us they had not felt supported by previous managers and had not been encouraged to develop their skills. The registered manager told us that they had identified that staff had not received the support they needed and had started supervisions with all staff. They had identified the training needs of staff and organised training as needed. Syringe driver training had been booked for nurses; senior care staff had started a 'clinical practitioner course' to be able to support the nurses. Staff told us they pleased to be completing the new training and it would improve the care they gave to people.

The provider had failed to provide appropriate support, training, professional development, supervision and appraisal as necessary for staff to carry out their duties. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were given an induction when they started work at the service, this was adapted according to the role they had. Care assistants completed training such as moving and handling, they then completed shadow shifts with more experienced staff to get to know people's choices and preferences. Staff discussed their needs with a mentor and staff were signed off when competent, and given extra time to feel confident in their role if needed.

Before coming to live in the service, people met with the registered manager, to discuss their needs and ensure the service could meet them. The assessment included all aspects of the person's needs including their physical, mental and social needs. The initial assessment was used as the basis for an initial two week care plan, before a comprehensive care plan was completed. The assessment included reference to best

practice guidance such as guidance from The National Institute for Health and Care Excellence (NICE) and guidelines were followed. The assessment included people's equality, diversity and sexuality needs and this was recorded within the care plan.

People's care plans were completed on an electronic database. The care plans were not always concise for staff to follow and could be contradictory. Staff continued to record all elements of people's care such as what people ate and drunk on paper records. There was a risk that people's needs and outcomes would not be addressed in an efficient way as two systems were in use. This was an area for improvement.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack mental capacity to do so for themselves. The Act requires that as much 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 their responsibilities under MCA. They told us how they supported people to make decisions and choices about their care and support. People's capacity to make specific decisions had been assessed and recorded. We observed people being given choices about where they spent their time and what they had to eat and drink. Best interest decisions were recorded and included people who knew the person well.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under MCA. The authorisation procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). We checked to make sure the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty are being met. Applications had been made in line with best practice. The conditions on authorisations that had been granted had been adhered to and extensions had been applied for when authorisations were going to expire.

People were supported to eat and drink to maintain a balanced diet. There was a choice of meals available to people. People told us that the chef was 'lovely' and met with them to discuss their likes and dislikes. The chef understood what people liked to eat and when they liked to eat it, arrangements were made for people to have their main meal at different times or have a different meal if the options were not liked.

Some people had difficulties swallowing and had been assessed by Speech and Language therapy as requiring a special diet such as puree. We observed the lunchtime meal and the pureed meals were well presented, each element of the meal was separate on plate. People had the choice of where they ate their meals, some people ate in their rooms, while others ate in the dining room.

The atmosphere in the dining room was quiet, there was very little interaction between people. People were encouraged to eat and drink independently, using special cutlery or straws. People who required assistance were supported by staff. People were not rushed with their meals and given time between each mouthful. People told us that the food was adequate or good, one person told us, "It is better than I could do myself."

Staff monitored people's physical and mental health and took action when they noticed any changes. People were referred to healthcare professionals such as a GP or dietician when needed and their advice was followed. For example, people were given nutritional supplements when prescribed. People told us they received regular visits from the optician and chiropodist.

The registered manager had started to work with the local safeguarding team and local GP surgeries to improve the support and care that people received.

Chaucer House was a purpose built building, to accommodate people's physical needs. The building included equipment such as specialist baths to support people's needs. People who were living with dementia, lived on the ground floor. Some adaptation had been made, for example, toilet doors in people's rooms were painted red. However, in the corridors the signage was not appropriate for people with dementia, there were no pictures and all the doors looked the same. During the inspection, one person was unable to find their room or the bathroom, they told us they all looked the same. This was an area for improvement.

Requires Improvement

Is the service caring?

Our findings

Relatives told us that staff were kind and caring but there was not enough of them. One relative told us, "The staff are very kind and caring, they have a laugh and sing with my loved one. There are not enough staff." Another relative told us, "The staff are excellent but there are not enough, they are always pushed."

The staff told us their vision of providing person centred care for people and supporting them to be independent and happy. However, this had not always been possible recently, staff told us that the shortage of permanent staff had meant that they had not been able to provide the care and support that people needed. This had meant that at times people had not been supported to meet their needs and this had caused people distress. This was observed at the inspection, when people had to wait for their bell to be answered for long periods of time.

Relatives and people told us that agency staff did not always know them and how they liked to be supported. The change in management had also meant that people and relatives felt that they were not always listened to when they expressed their views about the service. The registered manager told us that their priority was to reduce the use of agency staff and involve relatives in the development of the service.

Established staff had developed positive caring relationships with people and knew them well. Staff knew how to communicate with people, touching them on the hand and arm to reassure them and positioning themselves at people's eye level when speaking to them.

People told us that staff always knocked on their door before entering and closed the curtains when giving them care. We observed staff knocking on people's doors and waiting before entering. When assisting people in communal spaces staff were discreet when asking people if they needed to and supporting them to use the bathroom.

Some people living with dementia, liked to walk around the service, and often forgot where they were. Staff supported people in a positive way, reassuring them, and encouraging them to independent as possible. We observed staff speaking to people in an appropriate way. Staff were patient and gave people time to respond to questions and express themselves.

People's rooms contained personal items that were important to them including photographs and pictures of family members. People were encouraged to maintain relationships with people that were important to them. Relatives were able to visit at any time and were able to stay with their loved one, if they wanted. People were given the opportunity to spend quiet time with their partners, staff recognised that this was important for people and their well being.

Staff were aware of their responsibility to maintain people's confidentiality and documents were stored securely. Staff encouraged people to be as independent as possible, for example, using specialist cups, so that people were able to drink independently.

Some people were unable to express their views about their care, so staff ensured that decisions were made involving people who were important to them. Some people had nominated a person to represent them, however, some people had not. When this was the case, staff knew how to refer people to advocacy services when they needed support. An advocate is an independent person who can help people express their needs and wishes, weigh up and take decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf.

Requires Improvement

Is the service responsive?

Our findings

Relatives told us that established staff knew their loved ones and provided care that was personal to them.

Each person had a care plan. The care plans were stored electronically. The care plans had a pen profile of the person, that included all their like and dislikes and information about their lives before they came to live at the service. Assessments and information included their choice about the gender of carers that supported them and equality and diversity needs. This information was used as the basis for the care plan. One person had been admitted to the service on 8 November 2017, an initial transitional care plan had been completed but a comprehensive care plan had not been started at the time of the inspection. There was a risk that staff would not be able to give effective care as there was limited guidance available.

Some care plans had detail about people's choices and preferences, such as when they wanted to get up and go to bed and what drinks they liked. However, other care plans did not contain detailed guidance about the care the person required. For example, one person had a sling that they could sit on in their chair, so the sling could be used at any time to move them. This information was not in the care plan, though when we saw the person staff had ensured the sling was positioned correctly.

In another person's care plan, the care had not been changed due to the person having a pressure sore. Staff told us it had been agreed that the person should stay in bed until 11.30am, on their side to promote healing; this information was not recorded in the care plan. During the inspection, staff did not get the person up until late morning.

There was very little detail about people's communication needs in the care plans. For example, one person was not able to reliably communicate their decision and may become confused. The care plan did not explain to staff how the presented when they were confused. The care plan stated that 'staff to ensure the level of communication is appropriate to resident's needs at the time, but no information about how to meet the person's needs. Staff present during the inspection were observed successfully communicating with the person. There was a risk, if staff did not know people well, that they would not receive personalised care.

The provider had failed to maintain accurate, complete and contemporaneous record in respect of each service user. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before and during the inspection, concerns were raised by healthcare professionals and relatives, that people did not receive end of life care that was responsive to their needs. Healthcare professionals told us that people had not received medicines when they needed them, for example to relieve symptoms of anxiety. Relatives were concerned that their loved ones had not received pain relief that they needed because of staff shortages and the use of agency staff especially at night.

We reviewed the care plan and care notes of one person receiving end of life care. Records showed that pain

relief had been given regularly. The times recorded were outside the normal medicines round, which indicated that staff had given the medicines when needed. Care notes stated that the person had been in pain and medicines had been given. Records showed that staff had contacted healthcare professionals when required and had followed their guidance. There were night shifts when there were agency staff on duty who did not know the person and this was when concerns had been raised.

The care plan did not contain details of how to support the person and their family with end of life care. The care plan was an initial care plan that should only be used for two weeks and had only very basic information about the person. An end of life plan had not been developed with the person and their family to ensure that their needs were met. There was no guidance for staff about how to support the person's family. Concerns had been raised by families before the inspection. The registered manager told us they knew about the concerns that had been raised by relatives and would be working with them to resolve the issues.

The provider had failed to design treatment with a view to achieving the service users' preferences and ensuring their needs are met. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a complaints policy in place and this was reviewed regularly and displayed around the building. The policy was not available in different formats for people; the registered manager told us they would ensure that there were different versions available. We will check this at our next inspection.

People and their relatives knew how to complain. Some relatives told us that with the change of managers in the past year, they did not think that they had always been listened to. During the inspection, relatives told us about previous verbal complaints, and felt that these had not always been handled appropriately. The registered manager told us about verbal complaints that they had dealt with and this had been confirmed by the relative involved. However, the registered manager had not recorded these complaints and how they had been resolved. This was an area for improvement.

The service had received 11 written complaints in the last year. Relatives had contacted us before and after the inspection about the care their loved ones had received and the response from previous managers and provider to their complaints. Relatives told us they had complained a number of times before action was taken. Some relatives felt that their complaints had not been resolved to their satisfaction. We reviewed two complaints that had been received and saw that there was not always a complete record of the investigations carried out to resolve the complaint and complaints were dealt with informally by email. There was reference in the responses that some conversations had been had with members of staff however it was not always clear why issues had occurred to enable the service to learn from them and prevent them happening in future.

The service kept a log of complaints received which was updated on a monthly basis. It did contain some information about the outcome of the complaint and any further action taken such as "Discussed at handover". There was no overall analysis available to show that the service had reviewed all the complaints collectively to identify whether there were any themes or trends which could be addressed to review further and prevent similar complaints arising in future.

Following the inspection, the provider told us that they were now analysing complaints received to identify areas of improvement.

The provider had failed to take necessary and proportionate action to any failure identified by a complaint.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager kept a record of the compliments received. Compliments included emails and review forms that had thanked staff for their care and the level of care received.

There were activities on offer every day and some evenings. The activities were advertised around the building. These included art projects and spending time with children from a local school. The activities were varied and were provided in groups or individually on a one to one basis. During the inspection, we saw people enjoying the group activities available.

Requires Improvement

Is the service well-led?

Our findings

Before the inspection, concerns had been raised by relatives and healthcare professionals about how the service was managed and the impact this was having on the quality of care people received.

Since the last inspection, there have been management changes within the service. The previous registered manager left the service in February 2017. The service was then managed by temporary managers until the current registered manager joined the service in August 2017. Staff from all areas of the service had left since February 2017 and this had been managed by the use of agency staff. We received information from healthcare professionals, relatives and whistle blowers about the level of care being provided by Chaucer House. There were concerns about staffing levels, medicines management, staff not having the skills required to meet people's needs and the use of agency nursing staff.

During the inspection, we discussed with the registered manager and the Quality and Compliance Inspector, the issues that the service had faced over the last eight months and how they planned to improve the service. The registered manager told us that they were recruiting more staff and that the use of agency staff had decreased and would be stopped completely. They recognised that there were shortfalls with the care plans and training. There were training plans in place and senior carers, once trained, would be able to support the nurses allowing more time to complete the care plans. The registered manager had already taken action to reduce the incidents with medicines by changing the system and this had been effective.

While the service did not have a registered manager, there was a temporary manager in place. During this time, there was no evidence in the provider audit that the concerns of relatives and other agencies had been recognised as serious, requiring additional support and resources. This meant that the quality of the service received by people had continued to deteriorate.

Checks and audits had not been completed consistently. Audits including care plans, infection control and human resources had not been completed since July 2017. Health and safety checks and medicines audits had been completed regularly. An audit of the overall quality of the service by the provider had been completed regularly. There was an action plan for shortfalls found in all areas of the service but these had not been consistently effective as some of these shortfalls had not been rectified at the time of the inspection.

There was information about how the shortfall had been identified, but there were was not always dates, to show when. There was information about the action required and who was responsible. There was a date for when the action should be completed by but this had not been met on most actions. Regular updates had been completed on the action plan to record what had been done. The action plan did not identify what actions were urgent and when the dates for completion had not been met there was no additional action.

Records were not accurate and up to date. Care plans did not show person centred care was in place and did not always reflect the care provided.

The provider failed to maintain accurate records in respect of each service user. The provider had failed to fully assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they felt supported by the registered manager and were able to approach them about anything. They told us that the registered manager had put systems in place that had improved the care for people. Staff understood their roles and responsibilities, and senior carers were looking forward to increasing their skills to ensure people received the care they needed. Staff told us that the registered manager was visible within the service including weekends.

Relatives had mixed views about the registered manager; some told us they saw them regularly, others not at all. The registered manager told us that they had tried to meet as many relatives as they could and that this was ongoing.

The registered manager had promoted an open and transparent culture; they had built links with other agencies such as the local safeguarding team and local GP surgeries. The improvements in links to the GP surgeries had meant that issues with medicine ordering had been rectified. The registered manager had been open and honest about the improvements that needed to be made within the service and how they would involve the staff, people and families.

The registered manager held a daily meeting at 10.30am, with all the heads of departments, to update staff on any problems within the service. Senior staff told us these meetings were useful and ensured the registered manager was aware of the issues they were dealing with that day. The registered manager had held staff meetings in October 2017, to update staff on the changes that were happening within the services and to answer any questions they may have. A relatives meeting had been held in May 2017, but there were no minutes available.

Quality assurance surveys had been sent to relatives, people and staff. These had been analysed and an action plan had been put in place. Information displayed around the service did not always in formats that were easy for people to read, for example large print or pictorial. This was an area for improvement.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. This meant we could check that appropriate action had been taken. The manager was aware that they needed to inform CQC of important events in a timely manner.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating on a notice board in the office and on their website.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to design treatment with a view to achieving the service users' preferences and ensuring their needs are met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess the risks to the safety of people receiving care and treatment.The provider had failed to have sufficient numbers of competent, skilled and experienced persons deployed in order to meet people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to take necessary and proportionate action to any failure identified by a complaint.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to maintain accurate, complete and contemporaneous record in respect of each service user. The provider had failed to fully assess, monitor and improve the quality and safety of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to provide appropriate support, training, professional development, supervision and appraisal as necessary for staff to carry out their duties.