Uniquehelp Limited

Chestfield House

Inspection report

The Ridge Way
Chestfield
Whitstable
Kent
CT5 3JT

Tel: 01227792281
Website: www.njch.co.uk

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Chestfield House provides nursing care and accommodation for up to 31 older people, some of whom may also be living with dementia. The service is an adapted detached building in Chestfield near Whitstable. The accommodation is provided on two floors, with bedrooms on both the ground floor and first floor, accessed by a lift and a staircase. There are three shared bedrooms and most bedrooms have en-suite bathrooms. At the time of the inspection there were 30 people living at the service.

There was a registered manager employed at the service. A registered manager is a person who has registered with the 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. The registered manager was responsible for the day to day running of the service.

We carried out an unannounced comprehensive inspection of this service in May 2016 the service was rated Requires Improvement. There were breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and we asked the provider to make improvements. We issued requirement notices relating to failing to collaboratively carry out an assessment of people's needs and preferences, failing to mitigate risks to people, failing to assess and monitor the service effectively, failing to complete proper recruitment checks, failing to ensure staff were trained and failing to deploy sufficient numbers of staff. The provider sent us an action plan. We undertook this inspection to check they had followed their plans and to confirm they now met legal requirements. Improvements had been made and the breaches in regulation had been met.

Risks to people were assessed, identified, monitored and reviewed. However we found pressure relieving equipment that was not set correctly. Staff did not have clear guidance on the use of prescribed creams to make sure their skin was kept as healthy as possible. Other medicines were managed safely.

Some care plans had been rewritten and provided staff with more detail to help them provided people with personalised care. Other care plans remained generic and were in the process of being updated

Some audits and checks had not been consistently effective and shortfalls found during the inspection had not been identified. Other checks, such as the environment, had been completed and action taken to address any concerns. The area manager completed a 'provider visit' and audited the service The registered manager had taken action to address the shortfalls when they had been identified. We have made a recommendation regarding improving the audits.

People were protected from the risks of abuse, discrimination and avoidable harm. Staff knew how to report any concerns and felt confident that action would be taken. People's money was safely managed. Staff knew how to keep people safe and understood their responsibilities for reporting accidents and incidents to the registered manager. People's medicines were managed safely and they received them on

time. The premises were maintained to help keep people safe.

People were supported by sufficient numbers of staff who knew them and their preferences well and who had been recruited safely. Staff had completed regular training and one to one supervision to keep them up to date with guidance and best practice.

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. People's representatives and health professionals met to decide if the treatment was necessary and in the person's best interest.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. DoLS applications had been made to the relevant supervisory body in line with guidance.

People were supported to have a balanced diet. Staff monitored people's nutritional needs to help them stay as healthy as possible. Staff monitored people's health and worked closely with health professionals to keep people as healthy as possible.

People were treated with compassion and kindness. Staff had developed strong, caring relationships with people and their relatives. Staff were patient and provided people with information in a way they could understand. People's religious beliefs, ethnic and cultural needs were discussed and recorded to enable staff to provide the support people needed. People's preferences and choices for their end of life care were discussed with them and their loved ones. People's confidentiality, privacy and dignity were both promoted and maintained by staff.

People were supported to follow their interests and take part in social activities. People, relatives, stakeholders and staff were encouraged to provide feedback on the quality of the service. Concerns and complaints were investigated in line with the provider's policy.

There was good communication between the staff team and staff felt supported by the management team.

The registered manager had submitted notifications about important events that happened to CQC in an appropriate and timely manner and in line with guidance. The latest CQC report and rating was displayed in the service and on the provider's website in line with guidance.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Risks to people were assessed, monitored and regularly reviewed to help keep people safe.

People were protected from abuse, discrimination and avoidable harm.

Staff were recruited safely. There were enough staff on duty to keep people safe and meet their needs.

People received their medicines safely and on time.

Is the service effective?

Good

The service was effective.

People's needs and preferences were met by trained and knowledgeable staff.

Staff understood their responsibilities under the Mental Capacity Act and Deprivation of Liberty Safeguards.

People were supported to eat healthily and were involved in making decisions about what they ate and drank.

People were supported to remain as healthy as possible. People were referred to the relevant healthcare professionals when needed.

Is the service caring?

Good

The service was caring.

People were treated with compassion and kindness.

People were given the information they needed in a way they could understand.

People's confidentiality, privacy and dignity were promoted and maintained.

Is the service responsive?

Good

The service was responsive.

People received care and support that was centred on them as an individual; however, care plans were not all personalised and were still in the process of being rewritten.

People's preferences, likes and dislikes were considered by staff. People were supported to take part in social activities.

People and their relatives were able to share their experiences, raise concerns or complain.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Auditing processes were in place to check the quality and safety of the service provided. We have made a recommendation regarding improving the audits.

There was an open and transparent culture where people and their relatives were encouraged to provide feedback.

Notifications had been submitted to CQC in line with guidance. The latest CQC report and rating were displayed in the service and on the provider's website.

Chestfield 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.

The inspection took place on 21 and 22 September 2017 and was unannounced. The inspection was carried out by one inspector.

Before the inspection the provider completed a Provider Information Return. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we held about the service. We looked at notifications received by the Care Quality Commission. Notifications are information we receive from the service when a significant event happens, like a death or a serious injury.

During the inspection we reviewed people's records and a variety of documents. These included five people's care plans and associated risk assessments, three staff recruitment files, the staff induction records, training and supervision schedules, staff rotas, medicines records and quality assurance records. We spoke with six people living at the service and four relatives. We also spoke with the area manager, deputy manager and staff. We looked at how people were supported with their daily routines and activities and assessed if people's needs were being met. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Chestfield House was last inspected in May 2016 when five breaches in regulation were identified.

Good

Is the service safe?

Our findings

People told us they felt safe living at Chestfield House. People's relatives said their loved ones were safe and protected from harm. People said, "I feel quite safe" and "Of course I am safe here". Relatives commented, "After I have visited [my loved one] I can go home with happiness, knowing that they are safe" and "[My loved one] is very safe. They are well cared for. I don't need to worry about them".

At the last inspection in May 2016 the provider had not ensured that risks were mitigated. There was a lack of guidance for staff on what special equipment, such as hoists, people needed. There was no written protocol to make sure people's pressure relieving mattresses were checked to make sure they were working properly. We asked the provider to take action. Improvements had been made and the breach in Regulation had been met.

Risks to people were assessed, identified, monitored and reviewed. When people were at risk of developing pressure sores they had special air mattresses and cushions in place to relieve the pressure and were prescribed creams. There was a list in the office of what setting people's mattresses should be set on which corresponded with their weight. Some of the pressure machines had a note on to show what the setting should be and others did not. During the inspection there was one mattress which was incorrectly set. We brought this to the attention of the nurse and it was immediately corrected. The nurse checked all the remaining air mattresses and arranged for a sticker to be added on the settings panel of each one indicating the correct pressure setting.

People had charts in their rooms which noted what creams they needed to have applied to keep their skin healthy. These did not give staff all the information they needed. For example, the charts noted apply three times a day. There was no body map to show staff where the cream should be applied or how much should be used. The area manager told us that body maps should have been in place and agreed this was an area for improvement.

When people were living with diabetes there was clear guidance for staff about when to check people's blood sugar levels and what action to take if a person's blood sugar levels were too high or too low. Staff were knowledgeable about people's diabetes and told us when they would refer people to doctors or specialist nurses for further guidance and advice.

Some people needed special equipment, such as a hoist, to move from their bed to a chair. There was guidance for staff which had been reviewed and re-written since the last inspection. Staff told us they had completed training on how to move people safely. We observed staff moving people safely and reassuring people as they did so. The registered manager carried out competency assessments and observed staff to make sure people were supported to move safely. These checks were recorded and discussed with the staff. Care plans and risk assessments noted what equipment should be used including the hoist; sling and straps to make sure staff were able to support people to move safely.

At the last inspection the provider failed to ensure there were sufficient staff on duty to meet people's needs.

We asked the provider to take action. Improvements had been made and the breach in regulation had been met.

People were now supported by sufficient numbers of staff who knew them and their preferences well. People said that there were enough staff to give them support when they needed it. Staff told us there were enough of them on each shift to provide people with the care and support they needed. In addition to the care staff and nurse on each shift there was a cook, a kitchen assistant, two cleaners and one laundry person. An activities co-ordinator was employed for five afternoons a week so that the staff could concentrate on their care duties. The registered manager used a dependency tool to help decide how many staff were needed on each shift. They had been liaising with the Lead Clinical Nurse Specialist for Older People, Care Homes about the use of the tool to make sure the correct number of staff were deployed. Staff rotas showed that there were consistent numbers of staff on duty. The registered manager kept the staffing levels under review and had contingency plans to cover sickness or unplanned absence. During the inspection staff were not rushed and had time to spend sitting and chatting with people and their relatives. Calls bells were answered in good time.

At the previous inspection the provider failed to carry out the relevant checks to make sure that new staff were safe to work with people. We asked the provider to take action. We found improvements had been made and the breach in regulation had been met.

People were now supported by staff who had been recruited safely. Since the last inspection staff files had been reviewed and shortfalls had been retrospectively addressed. For example, gaps in employment history had been noted on the files. The area manager showed us the new style of application form being used which had addressed the concerns we raised. Staff files were organised and had a checklist at the front to make sure the contents of the file were correct. Recruitment checks were completed to make sure staff were honest, reliable and trustworthy to work with people. These included written references. Staff told us that checks were carried out before they started working at the service. Discussions held at interview were recorded and any gaps in people's employment were noted. Disclosure and Barring Service (DBS) criminal record checks were completed before staff began working at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care services. Nurses Personal Identification Numbers (PIN) were checked to make sure they were registered with the Nursing and Midwifery Council (NMC) and a note of the expiry date was kept to prompt the registered manager to check the PIN was kept in date. Nurses were completing the NMC revalidation when required. This is a process that all nurses and midwives need to follow to maintain their registration with the NMC by demonstrating they are practising safely and effectively.

People were protected from the risks of abuse, discrimination and avoidable harm. The registered manager referred to the local safeguarding authority for advice when needed. Staff knew what to do if they suspected incidents of abuse. Staff told said they received training on keeping people safe and were confident their concerns would be listened to and acted on if they raised them with the registered manager. Records confirmed staff had completed this training. People's money was locked away securely if people wanted money to be held on their behalf. Receipts were obtained with any purchases and recorded. Regular audits were completed to check the monies and records were correct.

Staff knew how to keep people safe and understood their responsibilities for reporting accidents and incidents to the registered manager. Incidents were recorded and reviewed to look for any trends. When a pattern was identified action was taken to refer people to the relevant health professionals, such as the dietician, speech and language therapist or doctors, to reduce risks and keep people safe. Staff followed any guidance provided by health professionals.

People's medicines were managed safely and they received them on time. Some care staff completed training on medicines management to support the nurses. Nurses administered people's medicines and completed additional training on the safe use of insulin and using a syringe driver. [A syringe driver is used to deliver a steady flow of injected medicine continuously under the skin to help reduce symptoms, such as sickness, agitation or seizures, or to control pain]. Some medicines required additional records and the registers for these were accurately completed. Staff made sure people had taken their medicines before they signed the medicines record.

Some people were prescribed medicines on an 'as and when needed' basis. There were guidelines in place for staff to follow about when to give these medicines. Staff monitored their use to check they were effective.

Medicines were stored and disposed of safely. The temperature of the room where medicines were stored was checked daily to make sure it was within safe limits. When medicines needed to be refrigerated there was suitable storage for these. There were appropriate arrangements in place for obtaining, recording, administering and disposing of prescribed medicines, in line with best practice. A medicines audit was completed regularly.

Regular health and safety checks of the environment and equipment were completed to make sure it was safe to use. These included ensuring that electrical and gas appliances were safe. Water temperatures were checked to make sure people were not at risk of scalding. Regular checks were carried out on the fire alarms and other fire equipment to make sure they were working properly. Fire exits were clearly marked and regular fire drills were completed and recorded. Staff knew how to respond and leave the building in the case of an emergency. Each person had a personal emergency evacuation plan (PEEP) in place. A PEEP sets out the specific physical and communication needs of each person to ensure that people could be safely evacuated from the service.

Good

Is the service effective?

Our findings

People received effective care from staff who had the skills and knowledge to carry out their roles. One person told us, "The staff know how I like to be looked after" and a relative commented, "They [the staff] know [my loved one] well. They know what [my loved one] likes and how they prefer things to be done. That puts my mind at rest". A member of staff said, "We work effectively as a team".

At the last inspection in May 2016 the provider failed to ensure staff received appropriate training and supervision. We asked the provider to take action. Improvements had been made and the breach in regulation had been met.

New staff completed an induction when they started working at the service. This included familiarisation with the building and the provider's policies and processes. New staff completed the Care Certificate. The Care Certificate is an identified set of standards that social care workers adhere to in their daily working life. Staff told us they shadowed experienced colleagues to get to know people, their needs, preferences and routines.

People were now supported by staff who were knowledgeable and knew them well. Staff had completed regular training in topics such as fire awareness, moving people safely and keeping people safe, to keep them up to date with guidance and best practice. During the inspection staff moved people safely and explained what they were doing to ensure people were reassured and remained comfortable whilst being supported to move. An extensive training programme gave staff the opportunity to complete additional courses that were relevant to people's needs. For example, staff told us they had attended training courses about strokes, diabetes, epilepsy and dementia. One member of staff said, "The dementia training gave me a better insight into how it must feel to be living with dementia. That insight means that I can support people with true empathy". Some of the training was completed on-line. The registered manager and area manager checked staff understanding and competence through discussions. The deputy manager told us that some staff preferred face to face training and that this was arranged. They said, "The training is good. Some staff might find learning difficult. We give additional help to those staff who need extra support to complete training". Nurses received clinical supervision and specialist training on topics such as dysphagia [difficulty in swallowing], catheter care, palliative care and tissue viability.

Staff were encouraged and supported to complete additional training to aid their personal development. This included social care vocational qualifications. Vocational qualifications are work based awards that are achieved through assessment and training. To achieve vocational qualifications, candidates must prove that they have the ability (competence) to carry out their job to the required standard.

Staff told us they met with the registered manager or deputy manager regularly to discuss their performance. They said they felt supported by their colleagues and by the management team. One member of staff commented, "We work as a close team to make sure people get everything they need, when they need it. The manager and deputy manager are both very supportive".

People told us they were able to make day to day choices such as what time to get up / go to bed, what they wanted to wear and eat and how they would like to spend their day.

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 their responsibilities under the MCA. Meetings were held with the relevant parties to make decisions in people's best interest. When people had to make important decisions, for example, about invasive medical treatment, information about the choices was presented in ways that people could understand. People's representatives and health professionals met to decide if the treatment was necessary and in the person's best interest.

Some people had made advanced decisions, such as Do Not Attempt Cardiopulmonary Resuscitation (DNACPR), this was recorded and kept at the front of people's care plans so that people's wishes could be acted on. These were reviewed to make sure they were still what the person wanted.

Staff had been trained about the MCA and put what they had learned into practice. Staff asked people for their consent in a way they could understand before they gave support. They spoke clearly and slowly and patiently waited for people to answer. When needed staff repeated the question to make sure that people understood. People's capacity to consent to care and support had been assessed. If people lacked capacity staff followed the principles of the MCA and made sure that any decision was only made in the person's best interests. For example, some people were subject to restrictions to their freedom of movement including the use of bed rails which prevent people from falling out of bed. The use of such measures had been discussed with people's relatives and health professionals and was recorded to show that these were the least restrictive options available.

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 the MCA. The authorisation procedures for this in care homes and hospitals are called the 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 were being met. Applications had been made in line with guidance.

People were supported to have a balanced diet. People told us they enjoyed the food. They said, "The food is pretty good", "The cook is wonderful" and "There is a choice of lunch and sandwiches at teatime".

Meals were social occasions and people sat together in the dining room. There was a happy atmosphere and people enjoyed their food and ate well. Staff were attentive and supported people to eat when needed. This was done discreetly to protect people's dignity.

People were involved in making decisions about what they ate and drank. They were asked during regular residents meetings if they were happy with the food and if they would like something added to the menu. When people made suggestions these were listened to and acted on. For example, over recent months people had requested more pasta, rice and spicy dishes and these had been added to the menu.

The cook knew people's likes and dislikes and any food intolerances to make sure people ate the things they preferred in a way that suited them best. When people were on a 'soft diet' each part of their meal was

mashed or pureed so they could taste each individual food. The cook used pictures of different meals to support people to make their choices. Snacks were available if people were hungry throughout the day.

Staff monitored people's nutritional needs to help them stay as healthy as possible. Some people were at risk of malnutrition or dehydration and staff completed food and fluid charts to check that people were eating and drinking enough. Some people needed to be fed with a Percutaneous Endoscopic Gastrostomy (PEG) - This is where a feeding tube in the stomach is used for people who cannot obtain nutrition through swallowing. When people used a PEG their care plans contained additional information specific to their individual needs. This included guidance for staff on what to do if the PEG became blocked or removed and the timescales they needed to respond in.

People were supported to remain as healthy as possible. Staff monitored people's health and worked closely with health professionals, such as GPs, speech and language therapists and diabetes nurses. A nurse told us, "We work well with the local GP surgery and they come out when we ask them to". Staff spoke knowledgeably about what signs they looked for which might indicate a decline in a person's health. Action had been taken to contact health professionals for advice and guidance given was followed by staff.

The design and layout of the service was suitable for people's needs. Rooms were clean and bright. There was large, clear, bold signage around the service to help people find their way around. Pictures and photographs were displayed throughout the service. Various dementia themed mottos were on the walls, for example 'I have dementia. I also have the ability to laugh, love and live a joyful life'. A member of staff said, "Just because a person is living with dementia doesn't mean they can't continue to live a full life. We need to make sure they have the right support in place to help them do it".

Good

Is the service caring?

Our findings

People told us they were happy living at Chestfield House. One person commented, "The staff are the best". Relatives said, "The staff are loving and caring and do their utmost for people", "I feel it is like coming into my own home when I come here" and "The atmosphere here is lovely. Every single one of them [staff] is friendly". The atmosphere throughout the service was cheerful with people and staff chatting and laughing together. Comments about staff from a recent relatives survey included, 'They are a lovely team' and 'They work very hard'. Staff said, "People get excellent care here. The staff are committed to what they do".

People were treated with compassion and kindness. Staff had developed strong, caring relationships with people and their relatives. People were relaxed in the company of each other and staff.

People were supported and cared for by staff who knew them and their loved ones well. People's preferences and needs were recorded and each person had information in their care plan about their life history and the people that were important to them. Staff were able to talk with them about things and people that were familiar to them.

People were spoken with in an appropriate way. Staff were patient and gave people time to respond and supported them to express themselves. When people became anxious staff reassured people by sitting with them and holding their hand or placing a hand on their shoulder to comfort them. Staff showed concern for people's well-being and were knowledgeable about people's needs and preferences.

People's religious beliefs, ethnic and cultural needs were discussed and recorded to enable staff to provide the support people needed. The registered manager arranged for clergy from different denominations to visit when requested. The dates for upcoming church services were displayed in the service.

People's confidentiality, privacy and dignity were both promoted and maintained by staff. Staff knocked on people's door and waited for a reply before entering. Staff were discreet and sensitive when supporting people with their personal care needs and protected their dignity. Records were securely stored to protect people's confidentiality. Staff spoke with each other, people and relatives in a respectful way.

People were supported to maintain and develop relationships with people that mattered to them. Relatives told us they were able to visit whenever they wanted and stay as long as they wished. During the inspection people's friends and relatives visited, supported them with lunch and took them out for some fresh air. People were encouraged to personalise their rooms with their own possessions, such as photos, furniture and ornaments.

People who required them were provided with independent metal health advocates (IMCAs). IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person. Information about advocates was displayed in the service.

People's preferences and choices for their end of life care were discussed with them and their loved ones. These were clearly recorded to make sure staff could manage and respect people's choices and wishes for their end of life care. People had access to support from specialist palliative care professionals when needed. Staff made sure people and their families had the support and equipment they needed to ensure comfort and dignity remained the priority.

Good

Is the service responsive?

Our findings

People told us that staff responded to their needs. People and their relatives told us they knew how to complain if they needed to. A relative commented, "I would say if I wasn't happy with [my loved one's] care. If I am worried about something I go to [the deputy manager] or nurse on duty and they will help".

At the last inspection in May 2016 the provider was not carrying out collaboratively, with the person, an assessment of their needs and preferences. We asked the provider to take action. Action had been taken to improve the service and the breach in Regulation had been met.

Since the previous inspection some care plans had been rewritten and provided staff with more detail to help them provide people with personalised care. For example, when people were living with diabetes their care plans had been updated and contained more detail about how to monitor blood sugar levels and what staff should do in the event of a low or high blood sugar result to ensure the person received the right treatment. The provider had ordered a new electronic care planning system in August 2017 and this was due to be introduced before the end of the year. Other care plans remained generic and the registered manager and deputy manager were working with people and their relatives to update them.

Staff knew people well and had worked at the service for a long time. They were able to tell us how people's facial expressions and / or body language may be an indicator of how they were feeling. This needed to be recorded to make sure new staff or agency staff could provide personalised care to people in the way they preferred. For example, when a person had limited verbal communication the care plan noted staff should watch for visual communication. There was no guidance for staff about what visual signs they should observe and what they meant to the individual, such as signs of pain, sadness or anxiety.

When people were considering moving into the service the registered manager met with them and their representatives to talk about their needs and wishes. An assessment was completed which summarised people's needs and how they liked their support provided. This helped the registered manager make sure staff could provide the care and support the person wanted.

Each person had a page in their care file entitled 'involvement in care planning'. These had been introduced following the last inspection. They were used as a prompt to staff to make sure people and their loved ones were involved in planning and reviewing their care. A sign displayed on the noticeboard reminded relatives that people's care plans were reviewed each month and that they were invited to be involved should they choose to be.

During the inspection we found a number of people's Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) had been photocopied. The area manager agreed this was poor practice and immediately took action to check each person's care plan, removed any copied DNACPR and shredded them. A DNACPR notes in bold 'Do not photocopy'. They should not be photocopied in case a person's circumstances have changed or they have changed their mind.

Staff were observant and responded to people's needs. Call bells were answered promptly. As part of their continuous monitoring the registered manager regularly checked that people had call bells within their reach and that staff responded in good time.

People were supported to follow their interests and take part in social activities. Regular activities were planned inside the service and an activities co-ordinator was employed five days a week. People were asked during regular residents meetings and through an activity survey if they preferred group or one to one activities and their preferences were taken into account. When people liked to spend time in their room this was respected by staff and the activity co-ordinator assigned time to spend with them doing the things they preferred, such as having a hand massage or reminiscing about their past life.

People, relatives, stakeholders and staff were encouraged to provide feedback on the quality of the service. When suggestions had been made these were acted on to improve the service. The last resident survey had been completed in September 2016 and the registered manager had analysed and summarised the results. They looked at what the service had not done so well and took action to remedy this. For example, only 40% of people felt their clothes were always put away satisfactorily. The registered manager had added this as an allocated task to the afternoon shift. This had been followed up during residents meetings and records showed that people were happy with their laundry. Some people had told the registered manager that the survey was too long and they were in the process of designing a dementia friendly shorter version to empower people to complete the surveys with minimal assistance.

The registered manager monitored feedback received via an external care homes website. The service had received four positive reviews in the previous six months. People's comments included, 'The staff are consistently friendly, helpful and responsive to our requests', 'We wouldn't want [our loved one] to be anywhere else', 'I have always been struck by the friendliness and level of care [my loved one] has received' and ' A pleasure to visit, be welcomed and talked with by staff; always the same whatever time we visit'.

Concerns and complaints were investigated in line with the provider's policy. People and their relatives told us they would speak with staff if they had a concern and they felt they would be taken seriously and that action would be taken.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives felt the service was well-led. They said they could speak to the management and staff at any time and felt they would be listened to. A member of staff commented, "It is like a family here. Most staff have been here a long time. The management are brilliant. The door is always open to people, their relatives and staff"

At the last inspection in May 2016 the provider failed to establish and operate effective systems and processes to assess and monitor the quality of the service. We asked the provider to take action. Some improvements had been made.

Some audits and checks had not been consistently effective and shortfalls found during the inspection had not been identified. For example, the incorrect setting on a pressure reliving mattress, photocopied Do Not Attempt Cardio Pulmonary Resuscitation forms and a lack of guidance for staff regarding the use of prescribed creams.

We recommend the provider includes checks on these areas in the audits to drive improvements and deliver a consistent quality of care.

Other checks, such as on the environment had been completed and action taken to address any concerns. The registered manager completed regular competency and observation checks to make sure people were receiving the care and support they needed. Other checks on areas such as medicines management, infection control and accidents and incidents were completed.

Each month the area manager completed a 'provider visit' and audited the service, covering the topics aligned with the Care Quality Commission's (CQC) Key Lines of Enquiry to check the service was safe, effective, caring, responsive and well-led. When they identified a shortfall an action plan was written which highlighted what actions needed to be completed, by whom and a completion date. These had been followed up at subsequent visits to ensure they had been completed. The registered manager had taken action to address the shortfalls when they had been identified.

Staff spoke with each other and with people and their relatives in a kind and respectful way. There was good communication between the staff team and a handover was completed at the beginning of each shift to make sure they were up to date with any changes in people's needs. Staff told us, "The teamwork is very good" and "I am very proud of what we do". Staff had worked at the service for a long time and there was a low staff turnover. Staff told us that they actively took part in staff meetings and that records were kept of meetings and notes made of any action needed. They said they attended one to one supervision meetings and felt supported by the registered manager.

Staff told us they enjoyed working at Chestfield House and understood their roles and responsibilities. They said, "I treat people as though they were my own mum or dad" and "I am lucky to be doing this job and to be able to help people through the latter part of their life". Staff spoke with us about the services values and

objectives. These had been built on the NHS '6 C's' Compassion in Practice – care, compassion, courage, communication, commitment and competence. Staff said, "Staff are passionate and give really good care. We are all committed to the care and emotional well-being of people".

People, relatives, visiting professionals and staff were encouraged to provide feedback and contribute ideas for the service. People took part in monthly residents meetings. When people chose not to attend the residents meeting their keyworker spoke with them on a one to one basis to make sure they were given the opportunity to provide feedback. A keyworker was a member of staff who was allocated to take the lead in co-ordinating someone's care. Each person had their own keyworker.

The provider had a range of policies and procedures in place that gave guidance to staff about how to carry out their role safely. Staff knew where to access the information they needed. When we asked for any information it was immediately available and records were stored securely to protect people's confidentiality. We found occasions when the name used in the content of the care plan was not that of the person whose plan it was. This showed a lack of respect for the person and a lack of care and attention to the detail in the care planning. Care plans required additional information when people were unable to communicate verbally. For example, facial signs / body language. This would support new staff or agency staff to provide personalised care and recognise if people were in pain or anxious. Following the inspection the area manager contacted CQC and confirmed the care plans were being transferred to the new electronic system and that people's communication needs were being updated.

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 to CQC 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. The latest CQC report and rating was displayed in the service and the details were also on the provider's website.