Stonehaven (Healthcare) Ltd

Chollacott House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 16 November and 23 November 2016 and was unannounced. Chollacott House is a nursing home which provides nursing and personal care for a maximum of 42 people, many of whom have complex nursing needs. This includes people who have had a stroke, or who have long term medical conditions such as diabetes and dementia. The home also provides care for people convalescing or needing a short period of respite as well as people needing end of life care. Drake unit has nine beds and provides care for people with neurological conditions such as Huntington's disease, Muscular Dystrophy, Motor Neurone Disease and head/brain injuries. 36 people were being cared for at the home when we visited, one of whom was in hospital. The provider is Stonehaven (Healthcare) Ltd, and there are eight homes in the group.

The inspection was to follow up if the required improvements had been made following our last inspection on 7, 13 and 18 April 2016 when we identified four breaches of regulations, related to quality monitoring, safe care and treatment, dignity and respect and consent. We took enforcement action in relation to the quality monitoring breach, by serving a warning notice on the provider and registered manager. This required the provider to make urgent improvements in this area by 30 September 2016. This was because the provider's quality monitoring systems were not effective, because they did not do all that was reasonably practicable to identify and mitigate risks for people. We issued requirements for the other three breaches of regulations. Previously the Care Quality Commission had identified breaches of regulations at an inspection in January 2015, two of which still had not been addressed in full at the April 2016 inspection.

Prior to this inspection, some concerns from relatives were raised with the Care Quality Commission, about people at the home falling and injuring themselves. We also received anonymous concerns about staffing levels, leading to poor care and about staff not reading or following care plans. We contacted the service to seek additional information about these concerns and spoke with the local authority, who investigated a relative's complaint and were satisfied with the assurances received.

The week before the inspection, the service notified us about a person who had fallen and injured themselves, and needed hospitalisation. During the inspection, we received a notification about another person who had developed a pressure ulcer. This focused inspection was to follow up whether the service had met the warning notice and check on the safety of people living in the home. This report only covers our findings in relation to these topics. You can read the report from the last comprehensive inspection by selecting the 'all reports' link for Chollacott House Nursing Home on our website at www.cqc.org.uk

The service has a registered manager. 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.

Since the inspection in April 2016 we have received an action plan from the provider which outlined the

improvements being made. The service has also worked in partnership with the local authority quality assurance and improvement team to improve their systems and processes.

Risk assessments and care plans were inconsistent in that some lacked sufficient detail on measures needed to reduce risks, for example in relation to nutrition/hydration and pressure ulcer risks.

People were at increased risk because daily records of food/fluid intake for people were poorly completed. Daily records for nine people showed they were at increased risk of malnutrition and dehydration. There were no records of any action taken in response to inadequate fluid intake or gaps in records about whether people had been given their meals. However, our observations showed people in their rooms and in communal areas were supported to eat and drink regularly. On several occasions, we saw staff offering people snacks and supplement drinks in between meals. Kitchen records confirmed some people were having food supplements, and there was a record confirming each person's meals were sent from the kitchen each day. This suggested daily records could not be relied on as an accurate record of what people had actually eaten and drank.

People were not being fully protected from the risks of acquiring pressure sores. Care staff checked the pressure relieving equipment each day, although no records of these checks were kept. When we asked care staff what checks were needed, their responses showed many staff did not know what checks were needed. We identified two people's pressure relieving mattresses were not at the recommended setting for the person's weight, which increased their risk of skin damage.

People were not fully protected because the quality monitoring systems in place were not fully effective. This was because this inspection highlighted new risks for people relating to poor records of food/fluid intake, a lack effective checks of pressure relieving equipment and some gaps in care plans. These findings demonstrated the systems in place to assess and monitor the quality of the service provided were still not fully effective. This was because they were not identifying, and minimising some risks relating to the health, welfare and safety of people using the service. Further improvements in quality monitoring were still needed.

We followed up concerns raised with the Care Quality Commission about whether staffing levels at the home were adequate to meet people's needs and keep them safe. Most people and relatives said they thought staffing levels were sufficient to keep them safe. Most people said they could get up and go to bed at a time of their choosing, although one person said they would have liked to have got up earlier that morning. People's personal care needs were met, they could have a wash, shower or bath. Where people needed two staff to care for them, they were always available, which staff confirmed. Staff were busy in the morning but worked in a methodical and organised way and at a time and pace to suit each person. Staff responded promptly to call bells, usually within five minutes. Any gaps in staffing were met by existing staff working extra shifts and by the use of regular agency staff. Some discussions were underway about whether night staffing levels needed to be increased.

External professionals generally reported confidence in the service and said staff worked well with them. The registered manager, deputy manager and clinical lead were working with the local authority quality assurance and improvement team to improve their systems and processes, and a further visit was planned to monitor progress.

Significant improvements had also been made in cleanliness and infection control. People were cared for in a clean, hygienic environment and there were no unpleasant odours in the home.

People received their medicines safely and on time and significant improvements had been made in the safety of medicines management.

People were protected from potential abuse and avoidable harm. Staff had received safeguarding adults training and knew how to report concerns internally and to external agencies. Robust recruitment checks were completed to ensure fit and proper staff were employed.

Two ongoing breaches of regulations were identified at this inspection. We will carry out a further inspection within the next six months to check the remaining requirements have been met. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

Some aspects of the service were not safe.

Risk assessments and care plans were inconsistent in that some lacked sufficient detail on measures needed to reduce risks.

People's risk of developing pressure ulcers was increased because checks of pressure relieving mattresses had not identified two were incorrectly set.

Staffing levels were sufficient to safely meet people's needs, although a review of night staffing levels was underway. This was following feedback from some night staff that they needed to be increased.

Staff knew about their responsibilities to safeguard people and how to report suspected abuse.

People received their medicines in a safe way.

A robust recruitment process was in place to ensure people were cared for by suitable staff.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

Although regular audits were carried out at the service, some quality monitoring arrangements were not effective. People's health was at increased risk because some areas which needed improvement, such as accuracy of daily records and checks of pressure relieving equipment were not identified through the audits carried out.

People, relatives, staff and external visiting professionals expressed confidence in staff and leadership at the home.

Significant improvements in systems for medicines management, infection control, and for complying with the requirements of the Mental Capacity Act (2005) had been made.

Chollacott House Nursing Home

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Chollacott House Nursing Home on 16 and 23 November 2016. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 7, 13 ad 18 April 2016 had been made. The team inspected the service against two of the five questions we ask about services: is the service safe, is this service well led? This is because the service was not meeting some legal requirements.

The inspection team comprised of one inspector. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the home. This included the provider's action plan, feedback we received from health and social care professionals, and from notifications. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We met with 26 people using the service, and spoke with 11 relatives. We looked at five people's care records and at nine people's daily records. A number of people living at the service were unable to communicate their experience of living at the home in detail as they were living with dementia. We therefore 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 comment directly on their experience.

We spoke with 15 staff which included the registered manager, deputy manager, clinical lead and with other nursing, care, catering, housekeeping and maintenance staff. We looked at systems for assessing staffing levels, monitoring staff training and supervision, staff rotas, and at four staff files, which included recruitment records for two new staff. We also looked at quality monitoring systems such as audits, checklists, staff and resident meeting minutes and provider visit reports. We sought feedback from commissioners, health and social care professionals and received a response from eight of them.

Requires Improvement

Is the service safe?

Our findings

People said they felt safe living at the home and relatives agreed. One person said, "They are wonderful, they make you feel very much at home." A relative said, "I feel she is safe, staff let the family know if they have any concerns." Staff also said they thought people were safely cared for at the home.

At the last inspection in April 2016 we identified people were at increased risk because of some aspects of medicine management needed further improvement and because of cross infection risks related to cleanliness of equipment, both of which had been addressed. However, new safety risks for people were identified at this inspection which meant there was a continuing breach of legal requirements.

People were not fully protected from the risks of acquiring pressure sores because staff were not using pressure relieving mattress equipment correctly. On 16 November 2016 the Care Quality Commission received a notification about a person who unexpectedly developed a grade three pressure ulcer, which we followed up when we visited on 23 November 2016. The person was admitted to the home with a skin wound which had previously been healing well. A tissue viability nurse specialist who visited the person identified their pressure mattress was faulty, so it was replaced. Following this, care staff were asked to check the pressure relieving equipment each day, although no records of these checks were kept. We asked four care staff what checks were needed but their responses varied. Only one of the four staff we spoke with demonstrated they understood the importance of checking each service users' pressure relieving mattress was at the correct setting for their weight in order to prevent tissue deterioration.

Guidance about recommended settings for weight ranges was printed on some equipment but not on others. Two people's care plans we looked at instructed staff to set the pressure relieving mattresses according to the person's weight, but did not specify what that setting should be. A list of each person's most recent weight was in the nurse's office. When we checked, we found the person, who previously had a faulty mattress, still had their mattress incorrectly set. In another person's room, their mattress was on a setting of seven, although the recommended setting for that person's weight was one. This significantly increased their risk of skin damage, due to the equipment being used on an incorrect setting. We immediately made the registered manager aware of this finding and asked for all other pressure relieving mattress to be checked. The deputy manager confirmed they checked the remaining 13 and confirmed they were all correctly set.

Individual risk assessments were completed and care plans written for any needs identified. For example, people at risk of malnutrition, dehydration, with choking/swallowing risks or those at risk of developing pressure ulcers. Risk assessments and care plans were inconsistent in that some lacked sufficient detail on measures needed to reduce risks, for example in relation to nutrition/hydration and pressure ulcer risks.

This was an ongoing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The day after the inspection, the registered manager contacted the Care Quality Commission to confirm the

correct settings were now marked on people's airflow mattresses, and staff were reminded to check them daily. Plans were being made to set up a system to check and document these the settings each day. Also, for nursing staff to review if those settings were correct, when each person was weighed.

We looked at the care of a person staff identified as at high risk of falling. Their care records showed the person had a tendency to fall at night. To try and prevent falls, their care plan instructed staff to lower the person's bed to be near the floor, to minimise risk of injury and check the person had their call bell and everything they needed each evening. Staff were also instructed to check the person hourly and prioritise answering their call bell if they rang. Following a review of their care plan in October 2016, a pressure mat was put beside the person's bed, to alert staff if the person tried to get out of bed alone so they could offer them assistance. Staff knew the person was at high risk of falls and checked on the person regularly.

The home notified us of a person recently injured who needed admission to hospital, after having five falls in one day and we followed up the care of this person. Their fall's risk assessment and mobility care plan identified they were at high risk of falling and could mobilise independently using a walking frame but needed some encouragement and reassurance to do so. Staff said they checked on the person regularly during the day, and did hourly checks at night. The registered manager said this person also had three hours of one to one staff support funded each day, because of their high needs, although this was not documented in the person's care plan. Staff said they had used these hours flexibly, depending on whether the person wanted company or preferred to be on their own in their room.

We were satisfied from looking at previous accident/incident reports that five falls in one day was highly unusual for this person, and that no particular triggers or themes were identified from previous falls. That day staff recognised the person was falling a lot and provided them with one to one staff support from lunchtime. Nursing staff closely monitored the person after each fall, and recognised signs that the person was becoming unwell and called the doctor appropriately, who arranged for them to be admitted to hospital. When the person's condition deteriorated further, staff called an emergency ambulance. The person was still in hospital, but staff were planning to ask the community therapy team to assess the person and were exploring with an occupational therapist further measures to minimise their risk of injury from falls.

The relative of a person, who previously lived upstairs, said they had been moved downstairs, when their risk of falling increased, which they found reassuring. This was so that staff could keep a closer eye on them. To minimise people's at high risk of falls, staff reminded them to use their walking aids and visited people in their rooms regularly to check on them. Staff spent time in communal lounge areas and anticipated people's needs by regularly offering people drinks and assistance to visit the toilet. We contacted the community therapy team who confirmed staff referred people at increased risk of falling to them, and followed their advice, although thought they may not receive as many referrals as expected, given the number and complex needs of people living at the home. Two other professionals thought staff were doing everything they could to minimise falls risks for people.

Accidents and incident forms were used to document any accidents or adverse incidents. Nursing staff reviewed all completed forms to ensure all appropriate steps were taken to reduce risks. Where a person sustained a bruise or a wound, these were documented on a body map, so they could be monitored, which is good practice.

We followed up concerns raised with the Care Quality Commission about whether staffing levels at the home were adequate to meet people's needs and keep them safe. Most people and relatives said they thought staffing levels were sufficient to keep them safe. One person said "mostly enough staff," a relative

said, "some staff do a lot of hours" and another said they would like more staff around to keep the person occupied during the day. Most people said they could get up and go to bed at a time of their choosing, although one person said they would have liked to have got up earlier that morning. People's personal care needs were met, staff said they could have a wash, shower or bath and people had regular nail care to make sure their nails were kept trimmed and clean. Some discussions were underway about whether night staffing levels needed to be increased.

Downstairs in the morning, there were six care staff and a nurse on Chollacott, with two care staff and a nurse on Drake Unit. In the afternoon, there was one nurse for both units, and five care staff. At night there was one nurse and two care staff on duty. The service used a dependency assessment tool to assess staffing levels, the tool was based on each person's assessed individual needs. The registered manager used staffing resources flexibly, for example, they identified the need for more staff in the early morning and evening to support people getting up, washed and dressed and in the evening to help people to bed. So, a member of staff started an hour early each morning and another worked until 10 each evening. The home had dedicated catering, housekeeping and maintenance staff, and an activities care co-ordinator, which meant care staff could spend more time with people.

Two care staff and a nurse had recently left and another nurse was leaving shortly and the registered manager had recruited two newly qualified nurses, who were undergoing induction and working as senior care assistants whilst awaiting registration. Any gaps in staffing were met by existing staff working extra shifts and by the use of regular agency staff. Rotas were prepared four weeks in advance, so staff knew which shifts they were working and any gaps in staffing could be filled well in advance. The rotas showed recommended staffing levels were provided, with staff working extra shifts to cover sickness, leave or any vacancies, or using agency staff when needed.

Staff were busy in the morning but worked in a methodical and organised way and at a time and pace to suit each person. Staff responded promptly to call bells, usually within five minutes. The call bell display changed tone to alert staff when a person had been ringing for more than six minutes. One person said they had waited a long time the previous evening for staff to respond to their call bell to assist them to use the toilet. We looked at the person's call bell data for the previous evening, which showed they waited nearly 12 minutes for staff to respond. The registered manager said they thought that was an unacceptably long waiting time, although bell data showed most other calls were responded to much more quickly than that.

Where people were confined to their rooms, records showed staff checked on people regularly and supported them to eat and drink and change position. Where people needed two staff to meet their personal care and moving and handling needs, staff confirmed were always available. At lunchtime, people who needed staff support with eating and drinking were helped to do so. The afternoons were quieter and staff spent more time sitting and chatting to people.

The October 2016 provider quality monitoring report showed a member of nursing staff on night duty had raised concerns about the need for a fourth member of staff on duty. Two care staff had also raised some concerns about night staffing levels during supervision meetings. Staff said they thought night staffing levels were safe but that it was very hard work on busy nights. Also, some staff worried about only having one staff member to supervise the whole home, when two staff were tied up in a room. Also, because workload meant night staff could not always assist people who wanted to get up very early. Some random sampling, on data about frequency of checks via the bell system showed people received regular night checks, although it was not possible to look at this in any detail and the registered manager said they did not routinely monitor this data to assess adequacy of staffing. They had discussed night staff with the provider and were planning to work a night shift to reassess adequacy of current night staffing levels.

People received their medicines safely and on time and significant improvements had been made in the safety of medicines management. Staff who administered medicines were trained and assessed to make sure they had the required skills and knowledge. Where a person's medical condition required them to receive their medicines at set times, staff made sure this happened. This meant the person was able to gain the maximum benefit from their medicine.

At our last visit, we raised concerns about the temperature in the medicine room on Drake unit exceeding recommended temperatures for storing medicines, which might affect their effectiveness. In response, the provider had purchased a specialist refrigerator, which stored medicines at 19-20 degrees, which met manufacturer's guidelines. Medicines which needed cold storage between five and eight degrees were stored in a separate fridge and both fridge temperatures were monitored daily.

Medicine Administration Records (MAR) sheets were audited weekly with actions taken to follow up any discrepancies or gaps in documentation. For example, missing signatures, any gaps in entries. A pharmacist had visited the home and provided advice and training for staff about medicines management. Oxygen was stored safely and securely with hazard signage available to display in people's rooms, although no one was on continuous oxygen when we visited.

Improvements had been made in documenting prescribed creams and ointments. Records of applying creams were now stored in people's rooms, and body maps were used to indicate where each cream needed to be applied and were well completed. However whilst some MAR charts had information for staff about how often creams should be used, others stated, 'to be used as directed by doctor'. Staff said where it was unclear, they got advice from nursing staff. Staff had met with the home's pharmacy supplier at the beginning of November 2016 to discuss further improvements. For example, in response, the pharmacist supplied 'standby' medicine for people going out for the day.

Significant improvements had also been made in cleanliness and infection control. People were cared for in a clean, hygienic environment and there were no unpleasant odours in the home. Staff had completed infection control training, washed their hands regularly and used protective equipment such as gloves and aprons to reduce cross-infection risks. Housekeeping staff had suitable cleaning materials and equipment and followed a daily cleaning routine, which included all bedroom, bathroom and communal areas. Rooms were deep cleaned on a rotational basis. Staff cleaned equipment such as hoists and wheelchairs regularly and made sure equipment such as call bell handsets were wiped regularly. Soiled laundry was appropriately segregated and laundered separately at high temperatures in accordance with the Department of Health's guidance. These measures had reduced people's risks of cross-infection. A recent environmental health food hygiene inspection of the kitchen had awarded the home a top score of five.

People were protected from potential abuse and avoidable harm. Staff had received safeguarding adults training and the provider had safeguarding and whistle blowing policies. This meant staff knew who to contact and what to do if they suspected or witnessed abuse or poor practice. There were secure arrangements to keep people's monies locked in a safe place, if they wished, to help protect them from financial abuse. All staff said they could report any concerns to the registered manager, deputy manager or clinical lead and were confident these would be dealt with.

Any safeguarding concerns identified had been notified to the Care Quality Commission and the local authority safeguarding team. They had been investigated and actions taken to protect people and keep them safe. For example, the registered manager reported concerns about abuse related to a person whose behaviours' challenged the service. They sought the advice of mental health professionals who reviewed the person's medication and implemented a range of further measures to reduce risks for the person and

protect others. Staff were encouraged to be open about concerns and monitor one another to ensure people were protected from harm at all times. At staff meetings, they discussed different scenarios, to raise awareness about their roles and responsibilities.

There was an ongoing programme of repairs, maintenance and refurbishment to improve the environment of the home. In the provider information return, we saw the maintenance person had fitted people's TVs to the walls, which meant people could now choose to watch TV from either their bed or armchair. Equipment was regularly serviced and tested and regular checks of the fire alarm system, fire extinguishers, smoke alarms, and fire exits were undertaken. Each person had a personal emergency evacuation plan showing what support they needed to evacuate the building in the event of a fire. A written contingency plan was in place in the event of a major emergency requiring evacuation of the home. Risks were discussed at staff meetings with further actions taken to reduce them.

Robust recruitment checks were completed to ensure fit and proper staff were employed, including for three volunteers working in the home. Staff had disclosure and barring checks (DBS), checks of qualifications, identity and references were obtained. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services.

Requires Improvement

Is the service well-led?

Our findings

The service had made significant improvements in relation to the concerns raised in the warning notice, particularly in relation to medicines management and infection control. However, this inspection highlighted new risks for people relating to poor records of food/fluid intake, a lack effective checks of pressure relieving equipment and some gaps in care plans. These findings demonstrated the systems in place to assess and monitor the quality of the service provided were still not fully effective. This was because they were not identifying, and minimising some risks relating to the health, welfare and safety of people using the service. Further improvements in quality monitoring were still needed.

People were at increased risk of developing pressure ulcers because daily pressure relieving equipment checks were not documented. There was no system to show what checks needed to be undertaken or record them. Care plans lacked information about individual mattress settings needed and visual daily checks had failed to identify two pressure-relieving mattresses were not at the recommended settings. This was despite a report to the Commission on 16 November 2016 where faulty pressure relieving equipment was identified as a cause of person's healing wound breaking down. Although monthly audits of pressure area care were carried out, the audit did not include whether checks of pressure relieving equipment were correctly carried out, so opportunities to identify incorrect mattress settings were missed.

People were at increased risk of malnutrition/dehydration because daily food and fluid intake records were poorly completed and lacked detail. This was despite the fact that risk assessments showed 13 people were identified as at increased risk of malnutrition/dehydration. For example, one person was confined to bed and had a pressure ulcer that was being treated. The person's risk assessment showed they were at high risk of malnutrition, due to their low body weight and they were
pescribed daily nutritional supplements. Their care plan said, 'I need encouragement to drink plenty of fluids. I need a high protein diet, encourage me to eat more.' It also said they needed reminding and regular staff assistance with eating and drinking.

We looked at the person's daily records for the previous two weeks to see how well they were eating and drinking. In daily records for the week commencing Saturday 4 November 2016, we found there were gaps on Saturday, Sunday and Monday about whether or not they had eaten lunch or supper. On four successive days, Saturday to Tuesday, week commencing 4 November 2016, their fluid intake over a 24 period was shown as 50 mls, 100mls and sips, 50 mls and 350mls respectively, all of which were so limited as to be inadequate amounts to keep them hydrated. In the daily records for the week commencing Saturday 12 November 2016, there were similar gaps.

The 24 hour chart in use did not include a section to add the total fluid amount drunk each day. This meant staff were not adding up the total fluid intake over a 24 hour period, and therefore did not know if each person had received a sufficient fluid intake. Furthermore, there were no records to show that staff were concerned or had alerted the nurse in charge to the person's poor eating and drinking. We saw similar poorly completed food and fluid records for eight other people we looked at, with no action taken in response to these recording issues.

When we spoke with staff they said the person ate and drank fairly well, they did not appear dehydrated and had not lost weight. When we asked staff how much each person was supposed to drink each day, their responses varied from 'not sure' to up to two litres. Although staff were unsure how much people needed to eat and drink to stay healthy, all staff said they would let a nurse know if a person wasn't eating or drinking. Our observations showed people in their rooms and in communal areas were supported to eat and drink regularly. On several occasions, we saw staff offering people snacks and supplement drinks in between meals. Kitchen records confirmed some people were having food supplements, and showed each person's meal was sent from the kitchen each day. The lack of records meant people were at increased risk of poor nutrition and dehydration and poor or record keeping was not being identified through the quality monitoring arrangements in place.

The lead nurse and registered manager both did monthly audits of care records, however, these only looked at nursing records. When we asked about monitoring daily records, the lead nurse said these were checked daily by a senior care worker and staff who reported any concerns to the nurse in charge. However, day to day checks by nursing staff and senior care workers had failed to identify and address these risks.

At our previous inspection we had raised concerns about a person calling out for help, as their call bell wasn't working. The provider information return showed staff checked call bells daily and staff confirmed they completed these checks, but didn't document them. On the first day we visited we heard one person calling out when we went upstairs, and there were no staff nearby. When we went to the person, we found their call bell wasn't working. We identified this to staff who arranged for a member of maintenance staff to rectify this by changing the battery. On the second day, a call bell monitor showed a lead fault in another person's room. We asked two care staff what the 'L' code displayed in the corridor meant, but they were not familiar with the code displayed, or what it signified. This suggested some staff needed more training/instruction on the call bed system in use. At our request, staff went to check on the person, and identified and resolved the problem.

Accidents/incidents were monitored to identify themes or trends, although these were very confusing as there were five different pieces of paper used in the audit.
Nursing staff did a monthly audit of people's individual falls, and numbers of incidents were also marked on a chart on the wall. The clinical lead looked at the nursing audits and collated information about whether incidents happened during day or at night and wrote detailed reports. The reports were discussed with the registered manager and highlighted particular people at risk, and changing risks. However, the reports seen didn't show information such as times of day or night, although this data was gathered and might have been useful in considering individual risks and night staffing needs.

This is an ongoing breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed accident/incident audits with the registered manager and clinical lead, who recognised the audit needed to be improved further. Following concerns raised about checks on pressure relieving equipment the registered manager contacted us to outline further steps taken to address them including plans to discuss further in staff meetings and improve monitoring by the clinical lead and nursing staff. Call bells were serviced and checked by the company the day after the inspection and were reported to be in good working order. A list of what the codes meant was displayed in staff room, nurse stations and on notice boards to remind staff.

People, relatives and professionals were all positive about the quality of care provided at the home. One person said, " Staff are kind and lovely, quite happy here." Another relative who visited the home daily said,

"The regime is good, it runs like a military campaign, if any problems, the care staff involve the nurses immediately." Recent survey feedback from people, relatives and professionals was also very positive.

People and relatives said they said they wouldn't hesitate to raise issues with the nurse in charge or one of the managers, and were confident they would address any concerns. For example, a person upstairs raised a concern about where staff were storing hoist equipment as it was making it difficult for them to move around the home in their wheelchair. This was addressed straightaway with written communication to all staff to remind them.

The service had a registered manager who didn't have a nursing background, so professional nursing leadership was provided by a clinical lead, who worked 24 hours a week at the service. They worked six hour shifts on Cholacott and Drake unit on alternate weeks and spent the remaining hours undertaking quality monitoring and advising on nursing practice. Staff gave us positive feedback about working at the home and said they felt well supported, worked well as a team and had good training and development opportunities. A professional said, "The registered manager has a good handle on things, she runs a tight ship." They said they were less confident about the clinical side and felt the clinical lead had a heavy workload.

External professionals generally reported confidence in the service and said staff worked well with them. Two said they thought continuity of qualified staff on Drake unit could be improved, as staff were moved around a lot. Another professional complimented staff on their willingness to take on and care for people with complex needs, who were challenging to look after. A professional who moved a person from another home to live at Chollacott said, "I didn't recognise her because she had improved dramatically from how she was." Other professional comments included; "Staff interested and eager to learn;" "The nurses are very organised and they know their patients."

The registered manager, deputy manager and clinical lead were working with the local authority quality assurance and improvement team to improve their systems and processes, and a further visit was planned to monitor progress. This included work to improve the quality of daily records, auditing accidents/incidents and service improvement planning.

The provider had a range of internal and external audits which were undertaken regularly. These included audits of hygiene and infection control, health and safety, complaints staffing levels, activities, training, medicines management and care records. A director in the provider organisation visited and spoke with people, staff and checked and reported on a range of areas, although not all areas were checked each time. The most recent report on 27 October 2016 showed they were aware of discussion about adequacy of night staffing levels and identified work needed to o improve the environment of the home.

A clinical lead for the provider also visited the home bi-monthly. Their most recent report on 10th November 2016 provided positive feedback about care and the home. Where issues were identified, the report showed they were being addressed. For example, building work to deal with rising damp in a corridor area. However, a section of the report on diet said, 'No current concerns with resident's intake.' Their audit of record keeping of four records was scored as 'good' overall. However, risk assessments were overdue for review in two sets of records and no weight or nutritional risks assessment was found in a third record. This meant gaps in food/fluid records hadn't been identified and the report was providing false reassurance to the provider in these areas. 'Mystery Shopper' visits undertaken bi- monthly by an external company. These involved someone visiting the home purporting to be looking for a home for their relative. The most recent visit two months ago reported positively on the home, awarding an overall score of 83%.

Regular residents meetings were held where people's views about the running of the home were sought.

This included checking whether people had concerns they wished to raise. For example, discussions about the menu and consultation on plans for bonfire night. Some people requested a take away meal, once a month, which staff had arranged. No formal complaints had been received directly by the service. However, concerns raised to CQC and to the local authority were investigated and promptly responded to, with requested information provided. A social worker who visited the home to investigate concerns said staff were open and provided all the requested information. They added that most of the concerns raised were not upheld from the information reviewed. A newsletter 'Daily Sparke' provided information, stimulation and interest for people.

Each day, a staff handover meeting was held to communicate any changes in people's health or care needs to staff coming on duty. A written summary of key information for each person was available as a quick reminder for staff and any agency workers. Senior care workers had a list of daily checks they did and reported any concerns to the nurse in charge.

The home were in the process of moving from paper-based records to electronic records, which meant currently, staff were using two record systems. Other homes within the group had already implemented the electronic records and the registered manager and clinical lead had visited other homes to see how they were used. The registered manager, deputy, clinical lead and nursing had been trained to use the system and nurses had started to use the electronic records upstairs in Drake unit. Care staff hadn't yet had their training but training was planned, with a view to implementation of full electronic care records by January 2017. Staff who had used the new system said they thought electronic records were a big improvement on the paper record systems currently in use and were much more legible than handwritten records.

Staff felt consulted and involved in decision making at the home. Regular staff meetings were held with all staff, minutes showed people's individual care needs were discussed, as was hygiene and infection control, equipment, training, record keeping and medicines management. Staff reported positively on training and development opportunities and received regular supervision. Where concerns were identified about individual staff practice, checks of individual staff records showed these were dealt with through supervision and capability procedures. A training matrix showed staff received all statutory and mandatory training such as first aid, moving and handling, infection control and fire training.

Staff had undertaken additional training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. For people who lacked capacity, systems had been developed to record and capture involvement of family members, staff and external professionals in 'best interest' decisions about people's care and treatment. For example, about use of bed rails, and whether to have annual flu injection and other medical procedures.

Systems for monitoring hygiene and cleanliness of the environment had improved. The housekeeper regular monitored cleanliness by, and registered manager did monthly audits of cleanliness and infection control which showed actions being taken to address any issues of concern. For example, replacing a carpet which remained odorous after deep cleaning. Further improvements in the laundry and kitchen were planned, in relation to an extension being planned for 2017. There was an ongoing schedule of redecorating and environmental improvements to make environment of care suitable for people living with dementia.

Staff at the home were working closely with St Luke's hospice to improve end of life care for people. The provider information return showed two staff gained the gold standard framework, for end of life care and several staff had undertaken the six steps end of life training with St Luke's hospice. Recently, the provider had been revalidated by 'Investors in People' standard which demonstrates a commitment to staff development. Staff from the home attended the local provider engagement network to update their

practice.

People's care records were kept securely and confidentially. The registered manager had notified the Care Quality Commission (CQC) about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe.

The provider has recently opened another home and employed a clinical lead to oversee all of the homes within the group. Following the inspection the managing director wrote to the Care Quality Commission to express their disappointment that the inspection highlighted further concerns. They outlined further action being taken to provide nursing support at manager level to Chollacott House and their intention rectify the shortcomings within days.

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 12 HSCA RA Regulations 2014 Safe care and treatment People were at increased risk because risk assessments and care plans were inconsistent and some lacked sufficient detail on measures needed to reduce risks. People were not fully protected from the risks of acquiring pressure sores because staff were not using pressure relieving mattress equipment correctly. Regulation 12 (1) (a) (b) (e)

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 People were not fully protected because the quality monitoring systems in place were not fully effective in identifying risks such as poor record keeping and inadequate checks of pressure relieving and call bell equipment. Regulation 17 (2) (a) (b) (c)