St. Cloud Care Limited

Chestnut View Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
Chestnut View is a residential care home that provide personal and nursing care for maximum of 60 older people who may be living with dementia and or a physical disability. The home accommodated people across three separate floors, one of which was for people with nursing care needs and one which specialised in providing care to people living with dementia. At the time of our inspection the service was providing care to 47 people.

People's experience of using this service:
People told us they felt safe living at Chestnut View. However, staff were not always visible in some parts of the home, and some people waited to get attention. Risks people faced were understood and assessed. There was some inconsistency in the way some risks were recorded and managed, and we made a recommendation about this. People received their medicines in a safe way. There was evidence of learning following professional feedback and some recent safety incidents.

People were supported by staff who had received appropriate training and induction. Staff communication was good, and people were referred to healthcare professionals in a timely way. People's nutritional needs were met and their views about their food was sought. We made a recommendation about more support for people living with dementia to choose their meals.

People's consent was sought before staff carried out care, but the documenting of decisions made on behalf of people who lacked mental capacity was not always in place. The service was not consistent in it approach to the requirements of the mental capacity act.

People were supported in a kind and caring way by staff and we had positive feedback from relatives about the care provided. Improvements had recently been made to ensure people had privacy and were always treated with dignity. We made a recommendation about staff engaging more with people who were nursed in bed.

People's preferences and interests were being updated to help staff give personalised care. However, we heard that some people's wishes were not always followed. Peoples' wishes for the end of their life were not always known or explored. Some people wanted more stimulation and daytime activity, or to be taken out on occasions. The provider had plans to improve things for people across the home and new activities staff were just in place. Complaints and concerns were responded to.

There was no registered manager in post. Over the past few months, and following feedback, the interim management had been making changes to improve the quality of care. There was an improvement plan in place. There was a positive atmosphere in the home. Some staff and some people did report being confused about who was in charge, however. Record keeping, deployment of staff and giving personalised care needed further improvement to ensure that good and effective care was consistently in place for people.

The provider demonstrated a willingness and commitment to address concerns and deliver high quality care. Improvements recently made needed to be embedded and sustained.

During this inspection we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also made three recommendations to the provider. Details of action we have asked the provider to take can be found at the end of this report. The provider was aware of some issues and started to take actions immediately following the inspection.

Rating at last inspection:
The last inspection report was published in March 2017 and the service was rated as Good.

Why we inspected:
This was an unannounced comprehensive inspection. The inspection was brought forward from the planned schedule following information we had received. The registered manager had left in December 2018 and the local authority had found some shortfalls and concerns at their visits. The concerns had been about staff levels and competence in key areas affecting the care of people with complex needs and about a lack of dignity and respect being shown to people. We followed up on these concerns at the inspection.

Follow up:
We will request an action plan from the provider to track what they do to improve the standards of care and safety. We will monitor the progress of the improvements working alongside the provider and local authority. We will return to visit in line with our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was caring. Details are in our Caring findings below.	**Good**
Is the service responsive? The service was not always responsive. Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our Well-Led findings below.	**Requires Improvement**

Chestnut View Care Home

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, 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 in part due to concerns received regarding safeguarding incidents and other information of concern. The information shared with CQC indicated potential concerns about the management of risk due to people's swallowing and eating needs, the moving and handling of people, medicines management and the premises and equipment. A decision was made for us to bring forward a planned inspection to be able to look at the risks.

Inspection team:
The inspection was carried out by two inspectors and a specialist nurse.

Service and service type:
Chestnut View is a residential care home that provides accommodation with both nursing care and personal care.

The service did not have a manager registered with the Care Quality Commission in place. A registered manager is legally responsible for how the service is run and for the quality and safety of the care provided. However, there was an interim manager in place, a deputy manager and a clinical lead. The regional manager also assisted us on the day of the inspection.

Notice of inspection:
The inspection took place on 11 April 2019 and was unannounced.

What we did:
Before the inspection we reviewed the information that we held about the service and the registered provider. This included any notifications and updates from the service and enquiries from the public.

Statutory notifications are information that the service is legally required to tell us about such as accidents, injuries and safeguarding investigations. We liaised with the local authority, who commissioned the service and have responsibility to safeguard people under the Care Act 2014.

The provider had not been asked to complete a provider information return (PIR) in time for this inspection. The PIR is key information we require providers to send us about the service, what the service does well and improvements they plan to make. However, the provider had sent us information and updates, prior to the inspection, on the service and changes they were making.

During the inspection, we spoke with seven people who used the service and four relatives about their experience of the care provided. We spoke with 10 members of staff including the provider, interim manager, registered nurse, care workers, activities and maintenance staff. We spent time observing staff practice and their interactions with people to help us understand the experience of people who could not talk with us.

We reviewed a range of information at the home. This included six people's care plans and the records relating to medicines and wound care. We looked at three staff files in relation to recruitment and supervision. A variety of records were reviewed relating to the management of the service, including policies and procedures, staff training, quality audits and notes of meetings, After the inspection, we received additional information from the provider. We also received feedback from three professionals about the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection, this key question was rated as Good. At this inspection, we found that some aspects of the service were not always safe. Recent improvements regarding staffing and risk management needed to be embedded and sustained.

Staffing and recruitment

● People were kept safe by enough staff being present in the building. The provider used a dependency tool to calculate how many staff hours were needed based on an assessment of everyone's needs. The regional manager said, "We review this monthly, or sooner if people's needs change.". One person told us, "I feel as safe as we can be. Staff check on us occasionally." A staff member said, "I feel the staffing levels are usually okay. We can ensure everyone gets the care they need."

● However, we found that staff deployment still needed attention. One person told us, "I would like a cup of tea, but no one is around to ask." We encouraged this person to use their call bell and a member of staff arrived after eight minutes. Another person said, "I act as their [people's] runner to get things for them if they need them, we can't always rely on the staff, we don't see them." One relative said, "I sometimes don't think there are enough staff. The activity on the sheets they give out don't always take place." We also saw members of staff rushing to get to another part of home to support people at lunch time.

● There had been a recent high turnover of care staff and an ongoing need to recruit. One person told us, "I think there's enough [staff]. We have been a bit short, but they are recruiting." One relative said, "They are trying to make it better here but it's a slow process. The biggest issue is staff.

The ongoing need to ensure staff are suitably deployed to meet people's care needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There had been success in recruiting new nursing and care staff and the provider was holding regular recruitment days. The regional manager said a new a general care assistant, who could be deployed where needed during the day, was being introduced. We were also told the ancillary staff were trained to assist with some care tasks and could be redeployed when required, although we did not see this happen.

● The recruitment of staff was safe. We checked staff files and found evidence the provider obtained two references, had proof of identity and a Disclosure and Barring Service (DBS) certificate before staff started work. DBS checks identify if prospective staff have a criminal record or were barred from working with people who use care and support services. The nurses were registered with their professional body, the Nursing and Midwifery Council.

Assessing risk, safety monitoring and management

● People at high risk of developing sores due to their immobility had the correct equipment in place and were being repositioned frequently. There were charts in place recording this was done correctly. Pressure relieving mattresses were in good working order and at the correct setting. One person at high risk of falls had a sensor mat in place and had continuous staff supervision when mobile. A person's care plan said they

needed a member of staff to assist them to mobilise due to being confused and frightened and we saw this was happening.

● There had been work to update people's care records to address concerns that had been found and minimise risk. For example, a person who had developed a pressure sore in December 2018, now had a good care regime in place and the wound was improving. Their care plan and records showed regular repositioning, dressings, skin care and diet were all being followed by staff.

● Environmental and equipment risks were addressed. For example, windows were fitted with restrictors to minimise any risk of a person falling. Hoists were used correctly and had been serviced. There had been fire safety and legionella checks and people had personal evacuation plans in place, so staff would know how to help them in case of an emergency.

● However, some people's records relating to the risks they faced were not always clear or used effectively to manage the risk. There were people assessed as at risk of dehydration but there was not a consistent approach to recording their fluid intake and output. Records were not always to hand for staff to complete. Where records were completed there were no fluid targets and people's intake varied with no action being recorded. We pointed this out to the interim manager who agreed to put in place a new system and ensure a more consistent approach.

● Guidance for staff about people's risks was also not always clear. For example, a person's care plan stated that they were at "High risk of falls," and needed, "To be an area where they can be observed". We saw they were in their wheelchair in a quiet spot at the end of a corridor. The risk was not great as they were able to use their call bell for help and understood when they needed help. Another person's record was contradictory, saying they were at medium risk of malnutrition in one place but with a nutritional score which placed them at high risk as they had been losing weight.

We recommend that people's identified risks, record keeping, and systems are reviewed and to ensure that accurate information and monitoring is always available for staff to act on.

Learning lessons when things go wrong

● Safety aspects in the home were being addressed following incidents that had occurred, and advice had been sought from care professionals. For example, the speech and language therapist had given guidance to staff after a person had a choking incident. The guidance about people's food and texture descriptions to help with swallowing risks were recorded and were acted on. The speech and language therapist reported staff they had met had shown interest and wanted to learn.

● Actions had been taken following the discovery that a person's care plan did not give staff adequate instruction about the care of their contracted hands. At inspection, the person's wound care plan was detailed and up to date. Staff ensured there was the correct skin protection and no further injury had been sustained.

● Accidents and incidents were reviewed, and action was taken. There was an analysis of falls that had taken place, including by location, time of day and by person to look for any trends. The interim management had acted after the local authority had raised concerns about lack of space to store mobility equipment and potential hazards in the home.

Systems and processes to safeguard people from the risk of abuse

● People were protected from the risk of abuse. One person told us, "Yes, I feel safe, I've not been worried by anything." One relative also said, "I'm confident with mum being here." Another said, of her mother, "She's really happy and settled here, there's never any harm to her."

● Staff were aware of their responsibilities to report concerns and abuse. All staff had completed training on the safeguarding of vulnerable people. There was information available to them to speak up if they saw anything wrong. One staff member said, "I think we keep people safe, comfortable and we develop

relationships with them."
● The provider had the systems in place to deal with safeguarding risks. The interim manager had been open with the authorities and investigated recent concerns. They had identified and acted to keep people safe in the future.
Using medicines safely
● Improvements had been made to ensure that people's medicines management was in line with safe practice. Actions had been taken following recent medicine errors or incidents. Eleven staff, including management, had attended a recent training session which covered all aspects of administration and ensuring good records.
● People's medicines were administered and recorded safely. We observed people received their medicines and saw safe and correct practice was followed. People's medicine administration records (MAR) were completed at the time and were up to date. Where people required a pain patch or special creams, body maps were used to show where these had last been applied. There were guidelines in place for those people who needed medicines 'as needed' (PRN).
● A medicines audit had been carried out by an external pharmacist. This identified safe practice at the home and only two actions were noted. One action was about the home getting pharmacist advice on the giving of medicines via a gastric tube, which affected one person. The interim manager was aware that action was needed.
● The storage of people's medicines was safe. There was a lockable clinical room on each floor, where a medicines trolley and refrigerator was kept. Temperature checks were being done and there was a system for returning unused medicines.

Preventing and controlling infection
● People were protected from the spread of infection. The home was in a good decorative state, and well cleaned including people's bathrooms and toilets and clinical rooms. Staff had access to aprons and gloves which were available in people's ensuite toilet area and the communal bathrooms. One staff member said, "I always use used them for giving personal care as expected."
● In the past few days there had been an outbreak of mild stomach upset affecting some people in the home. Precautions had been taken to stop the spread of this and on the nursing floor, where people were most vulnerable, people were confined to their rooms.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

At the last inspection we rated this key question as Good. At this inspection, we found the service was working hard to maintain this standard, but the effectiveness of people's care, treatment and support was inconsistent.

Ensuring consent to care and treatment in line with law and guidance

- The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
- People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
- Staff understood the principles of the MCA and of gaining people's consent. We observed staff asking people what they wanted to do, and seeking their consent, for example, to help a person to get dressed. One staff member said, "We have to respect them and their decisions."
- However, there was inconsistent approach to undertaking assessments of people's mental capacity. There was no capacity assessment, or a best interest's decision, recorded for a person who had bed rails for their own safety but was unable to consent to this. The recent external medicines audit had also picked up the need for capacity assessments for staff making the best interest decision to give medicines to people in a covert way.
- Where relatives made decisions on their behalf, it was not always clear why and the relevant legal authority seen. For example, one relative had signed their consent form but there was no evidence they had legal powers to make decisions for them. This was also the case for another person whose relative had signed the consent to care, despite their care plan stating they had mental capacity to make own decisions.

The service not always acting in accordance with the MCA 2005 which was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- At the inspection, we were given examples or recent mental capacity assessments that had been completed for three people. These were specific to relevant decisions such as the "Need for close observation," and for, "Use of bed rails." Following the inspection we were also sent a capacity assessment for one person who had their medicines administered covertly. The interim management were in the process of completing reviews and assessments with all those where their mental capacity was in question and this was noted on their improvement plan.

Supporting people to eat and drink enough to maintain a balanced diet

● People were supported at meal times to eat and drink enough. In one area, staff asked people who were not eating much whether they wanted something else. This meant one person asked for the bananas and cream, which was brought for them.

● People's nutritional and dietary needs and preferences were known. There was a daily list in place on each floor which detailed each person's requirements, following professional advice. One person's sheet said, "Needs help with eating and drinking and lots of assistance. Soft diet." At lunch time, care staff paid attention to this and supervised the person. They took out a soft portion from the pudding especially for them. Staff were also seen to check the folder for people's preferences and needs. One staff member also told us, "It is important to ensure the food and drink are the right consistency for the person. I encourage and chat a little, but not enough to distract them from eating."

● People living with dementia did not appear to be given a choice of food at lunch time. People were all served the same meal. We were told there was a meat dish and a vegetarian option at lunchtime and people chose their meal the day before. There was also an alternative and light bites menu for those who did not want the main options. However, we did not see this offered and people living with dementia may not remember a choice they made the day before.

We recommend people living with dementia are supported to have a choice of food and asked at the time of serving a meal.

Staff support: induction, training, skills and experience

● People were supported by staff who had received relevant training. One member of staff told us, "I have completed some face to face training and on-line training." At recent medicines training, staff were asked to audit practices and feedback which enabled their learning. One staff member who had attended said, "The training was very recent, and I learnt a lot."

● There was a record of what training each staff member had completed. This included mandatory e-learning training on the safe moving and handling of people, safeguarding of vulnerable people, falls prevention, and dementia awareness. All nurses had recently received training in wound care and care staff had undertaken training in positive behaviour support. One nurse told us they had completed their professional revalidation to practice as a nurse in September 2018.

● New staff received an induction before they started work. One member of staff said, "I have had two weeks shadowing. I am staying on this floor at the moment, so I can get to know the people and the routine." Those who were new to care work were also supported to complete the Care Certificate, which is a nationally identified standard for health and social care workers.

● Staff received supervision from a manager on a regular basis. One staff member confirmed, "I do have supervisions, and we have a good discussion to support me." There was a record kept of the dates of supervisions taking place.

Staff working together and with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives

● Communication between staff across the home was effective. There was a daily briefing session where a staff representative from each floor attended to share important information. There was also a handover between staff on each floor. One nurse said, "I check the diary and ensure everything is actioned. I allocate staff to people and ensure they know who needs what."

● People were referred to other agencies and professionals to ensure good care. Each person had a folder where any appointments and relevant health information was kept. For example, one person had been seen recently by the speech and language therapist and the letter of guidance was there. A person who was cared for in bed was given eye care, but the nurse told us," I will alert the doctor as the eye looks sore."

● The home had begun to hold a weekly clinical risk meeting between nurses and the deputy manager. This was to identify people at risk of health change or deterioration, such as nutrition, weight loss, wound care, repositioning, falls, or behavioural concerns and agree any specific actions.

Adapting service, design, decoration to meet people's needs

● People lived in an environment that met their needs. There had been recent work at the home to improve both the design and suitability of some areas of the home. For example, new and better flooring in one area where people living with dementia were living. The work undertaken had been planned carefully to minimise stress and disruption.

● People living with dementia were helped to orientate themselves with brightly painted walls with photos and items of interest. There were also signs that indicated whether a door led to a bedroom, a bathroom, toilet or lounge. People had access to a lift to be able to go between the floors, for an activity or to the garden.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's health and care needs were known and had been assessed prior to them coming into the home. Nursing care plans gave enough detail for staff to be able to care for people with more complex needs such as end stage Parkinson's disease or dementia. People who needed to be seen by staff every hour were receiving these visits to check on them. People's oral care needs were also recorded.

● The interim management was considering how best practice for people living with dementia care was being met across the home. An audit had been completed recently which identified some improvements, such as staff having access to more dementia training.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

At the last inspection we rated this key question as Good. At this inspection, we saw good examples of kind and compassionate care, but people were not always well supported in all areas of the home.

Ensuring people are well treated and supported; equality and diversity

- People were treated kindly by staff and with respect. One person told us, "Everyone is very kind." One relative said, "I'm impressed. The staff are very cheerful, and they are always welcoming." Another told us, "The staff are good, they always welcome me." At the last relatives' meeting there was positive feedback about the staff. .
- People living with dementia were supported in a sensitive and positive way. People doing an activity together were praised and the atmosphere was very happy. Everyone was spoken to by name and involved. We heard staff call people, "darling" when talking to them and making them feel special. People were supported with their emotions and anxieties. One person was distressed and confused on their own. A member of staff came over, held their hand for a while and then distracted them with the offer of tea and cake.
- We saw staff made time for people in some parts of the home and that most of this interaction was positive. One person told us about a staff member who, "Always has a smile and a friendly thing to say." On the nursing floor, however, we did not see staff engaging as much with people when carrying out tasks and we fed this back to the management.

We recommend that staff are supported and encouraged to socially interact with people when giving care.

Supporting people to express their views and be involved in making decisions about their care

- People were invited to make choices, such as what they wanted to drink and whether they liked sauce or gravy at the meal time. When medicines were being given staff explained what the medicine was for and patiently ensured the person was ready and understood. One staff member said, "We have to respect them and give them choices and respect their decisions."
- People were able to be involved and give their views on what would make a difference to them through the 'resident of the day' initiative. This was where staff, including housekeeping, chef and activities visited the person, and spoke with their family, to check whether anything could be changed for them. Their views were recorded and changes were made if needed. One person had asked the chef for an omelette to eat and a note was made about enjoying seeing the garden from their room. One relative told us, "Mum loves it here and gets on well with staff."

Respecting and promoting people's privacy, dignity and independence

- There had been improvements made to protect people's privacy and dignity, following feedback from the local authority. Net curtains had been put up to ensure visitors could not see into people's rooms on the ground floor. Individual face cloths had been purchased for people. One relative said there had been recent

occasions when, "No-one noticed [her mother] hadn't dressed herself properly and no one had time to help her." But she also said this was minor and they had seen an improvement.

● We observed staff treating people with respect and supporting their privacy. When one person with dementia came out of their room in state on undress, a member of staff was quick to support them into their room, saying kindly, "Do you want to get washed and dressed now."

● The provider ensured that agency staff, coming to work at the home, were given an induction and information about what was expected of them in their care giving and the standard to always treat people with dignity and respect. Action had been taken with staff who fell short of this standard.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection, we rated this key question as Good. At this inspection, some people's personal needs and preferences were not always known or met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support

● People's care plans contained some information to enable staff to give personalised care. There was also a space to record people's wishes under, "What is important to me." For example, this recorded the food people liked or did not like and their personal care routines. As the information was sometimes limited, there was ongoing work being done to review and personalise all care plans further.

● However, we heard that some people's preferences were not always being met. One relative said, "Mum likes a hot drink before she goes to bed, but it is not happening all the time. I find I have to remind staff." The person's request was written in their care plan. Another relative told us staff did not always help a person who was very hard of hearing to wear their hearing aids or follow the instructions about saving the life of the batteries. They said, "I have talked to the manager and would like to see more in the care plan."

● Some people also told us they would like more going on during the day and would like to go out. One person said, "I would like them to entertain us move. I have to keep myself active. Sometimes we used to go up to garden centre that hasn't happened for a while now. Another person said, "I would like to go out to the shops." A relative told us, "The home has a mini bus. They used to take people out but not anymore." A relative told us, "The activity on the sheets they give out don't always take place."

● People's personal wishes for their future care at the end of their life was not always recorded well or known. The management were aware of this and had recently had contact with a learning consultant with a view to improving end of life plans for people. We also identified that some staff could benefit from further training to confidently support people towards the end of their life and fed this back to the management.

Not doing everything practicable to meet people's needs and their personal preferences was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The interim manager was aware of the need to improve and had recruited more activities staff. They said. "Activities are taking place but not on each floor at the moment. We can do more when the new person starts. I would also like to see staff having more one to one time with people who are in their rooms." Following the inspection, the provider sent us their recent plan of improvements for social engagement and activities to address shortfalls.

● People living with dementia, on one floor, benefited from having a dedicated activities person. We saw a word quiz taking place in their lounge which was well run. Most people joined in and enjoyed this. The regional manager told us, "We are working to have a revamp and been getting advice to improve the activities that are suitable for people living with dementia."

● Some people were supported to do what was important for them. One person told us have "I have a visit

from the local church. l go on a Sunday to church if I want to."

● People were cared for at the end of their lives. Care plans for these people included how the person communicated. For example, one person on end of life care had a sensory impairment and their plan said, "Staff should observe body language and gestures …listen to [person] and give plenty of time. Remove all distractions." Pain relief was administered carefully to ensure the person was comfortable and the staff were aware of their needs.

Improving care quality in response to complaints or concerns

● People and their relatives felt able to complain and there was a process in place to manage complaints and feedback. In the last four months there had been six formal complaints. The pattern of complaints over this period, since the interim management was in place, did show some improvement. Each complaint was fully investigated, and a letter sent in response to the person who made the complaint. Apologies were offered in all cases.

● Some people we spoke with were unsure about who they would complain to. We informed the interim manager of this. Although a relative told us, "I would knock on of the office door about a query. They usually drop what they are doing and deal with your worry right away."

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection, this key question was rated as Good. At this inspection, whilst improvement actions were taking place, the leadership and culture did not always support the consistent delivery of high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; and how the provider understands and acts on duty of candour responsibility

●There was interim leadership in place at the service, since the registered manager had left about four months ago. The provider demonstrated a willingness and commitment to promote and deliver high quality, person centred care. They had been responsive to feedback and concerns raised by the local authority and put in place an improvement plan. The shortfalls we found, however, showed there was more work required to maintain progress and ensure that good care was in place for everyone.

● The provider had systems in place to review and monitor people's care and safety. The interim manager was supported by the regional compliance team to ensure quality assurance systems were in place. As well as the daily staff briefing and handover meetings, there was a weekly manager's check and monthly audits for medicines, mealtime experiences and use of call bells. There was an awareness that aspects of staffing, risk management, mental capacity assessments and people's care plans needed work and improvements had to be made.

● Management responsibilities were shared across the home with different senior staff involved. Some staff were not sure who was in charge. One told us, "I am confused about who the manager is. There are people here from head office too." Some people and relatives did not know the interim manager's name. One relative said, I always get a response at the office, but I couldn't say who was who." This meant that management had more work to do to ensure visibility and staff always knew who they reported to.

● Service commissioners told us about the impact of having no registered manager. For example, the home had not participated in the NHS quality incentive scheme. The local authority had, on two occasions, cause to visit to check on quality this year and had recommended improvements. We saw that action had and was being taken, but ongoing and robust management oversight was needed to ensure changes and standards were maintained.

The provider not being able to ensure that all requirements and care regulations were met was a breach of Regulation 17 (Good governance) of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The interim management had been open with the authorities about concerns and staffing issues as they arose. They had reported notifiable incidents and safeguarding incidents to the CQC and local authority. They had also fulfilled their duty of candour responsibilities to inform and be open with families where mistakes were made.

● Action had been taken to update the physical aspects of the home. This created some upheaval but had been well managed to reduce the impact on the people living at the home. Staff were encouraged to work together and there were photos taken and displayed to show how this happened and to praise the staff involved.
● Staff we spoke with were positive and felt supported by the interim arrangements. Action had been taken with staff who did not behave appropriately or safely. Staff handover meetings had been made mandatory. One staff member said, "It is now a happy place. We all give one hundred percent."
● New staff had also been recruited successfully. There was still a need to reduce reliance on agency staff and to recruit a new registered manager. The regional manager said, "We are looking for the right person and, in the meantime, we can make improvements. Following the inspection, we were told that an appointment had been made.

Continuous learning and improving care
● The provider had a continuous improvement plan in place. This evidenced improvements we saw at the inspection and identified that ongoing work was being done on mental capacity assessments, risk management and care plans.
● People's access to activities and outings was also an improvement area. The provider held a meeting in February which explored how they could extend the range of activities to meet people's preferences. An improvement was to develop specific care plans for people at risk of social isolation who may be in their rooms or in bed. Ideas would be taken to the relatives and residents forum for feedback.
● The provider had recently developed a "Dementia strategy" with the aim of improving the experience of people living with dementia in their care homes. At Chestnut View, a dementia provision audit had been done to identify some areas to work on. For example, to introduce hydration stations for people and to ensure decoration and environment supports people living with dementia.
● The provider had recently agreed a new vision as part of a rebrand of the organisation. This was, "Inspiring and enabling people to live a meaningful life, as part of a great life." Staff from Chestnut View had been invited to a meeting recently as part of the launch and had been thanked for their hard work.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There were opportunities for people and their relatives to have a say in the way the home was run. At a meeting on 20 February, information was shared about management cover and the replacement flooring. There was a concern raised about staffing at the weekend. In response, people were told about the successful recruitment of new staff. There was positive feedback about changes in the home such as a more welcoming reception area. There was no record of who had attended this meeting but there were notes which recorded people's views.
● One person, living in the home, had been involved in the recent recruitment of the new activities staff. They had attended the interview and were asked for their views. Candidates were also shown around the home and feedback from people was part of the selection process.
● Staff were involved through regular meetings. One staff member told us, "We had one about six weeks ago. It's an open house meeting and we have a chance to raise anything we want." Staff had been thanked for their hard work at the last meeting. There was also a good amount of instruction about the things care staff should or should not do, although staff we spoke with seemed motivated to deliver a good service.

Working in partnership with others
● The home has a partnership with Surrey Choices, which supports people with a learning difficulty to find work. Although we did not see anyone on our inspection, Chestnut View had employed people to help with cleaning and cooking in the past.

● The interim manager told us about contact with a local children's nursery that they were keen to re-establish links with. They said, "People love seeing the children."
● Connections were being made with the local Alzheimer's Society. Staff were being asked to sign up to become a "Dementia Friend" and work with the charity to raise awareness.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider was not doing everything practicable to meet people's needs and their personal preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service was not always acting in accordance with the MCA 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that all requirements and care regulations were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was an ongoing need to ensure staff are suitably deployed to meet people's care needs.