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Chester House Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was carried out over three days on 27 and 28 February 2017 and 1 March 2017. Our visit on 27 February 2017 was unannounced.

At the last inspection on 8, 9 10 and 30 August 2016 we rated the service as 'Inadequate' which meant the service was placed in 'special measures.' At that inspection we identified multiple regulatory breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014, which related to medication administration, safeguarding service users from abuse and improper treatment, fit and proper person's employed, safe care and treatment, staffing, person-centred care, dignity and respect and good governance.

Following the inspection the provider sent us information detailing how the identified breaches would be addressed. This inspection was to check improvements had been made and to review the ratings.

We saw that significant improvements had been made and all the regulatory reaches identified at the last inspection had been met.

Chester House Care Home is located in Hazel Grove, Stockport and can provide care for up to 14 adults with a range of needs.

Accommodation is provided on three floors, accessible by two stair lifts. There are twelve single bedrooms and two bedrooms that have the capacity to be used as shared rooms. However at the time of this inspection the rooms occupied were all single occupancy. At the time of our inspection there were eleven people living in the home.

No en-suite faculties are available.

The home has a lounge/dining room and a conservatory which is currently used as a smoking area as well as an outside garden to the rear of the property.

Since our last inspection the registered manager had left the service which meant there was no registered manager in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The home is currently being managed by the two registered providers who are both registered nurses and an assistant manager who is a qualified doctor.

The assistant manager and one of the registered providers were present during all three days of the inspection and were responsive to our feedback and were committed to further improving the service delivered to people living at Chester House Care Home.

We observed staff giving kind and caring support to people. We saw that people's privacy and dignity were respected and the atmosphere felt relaxed, friendly and homely. From our observations of staff interactions and conversations with people, we saw staff had good relationships with the people they were caring for.

Medicines were managed safely and people were receiving their medicines in line with the prescriber's instructions.

From looking at the training record and speaking with staff, we found improvements had been made to ensure staff were properly trained and future training had been planned.

Staff spoken with understood the need to obtain verbal consent from people using the service before a task or care was undertaken and staff were seen to obtain consent prior to providing care or support.

We saw that some refurbishment had been undertaken since the last inspection and was ongoing to improve the environment for the people living at Chester House. The home was clean and we saw staff had access to personal protective equipment (PPE) to help reduce the risk of cross infection.

There were no restrictions in place on people's movement within the home. On the ground floor the communal areas consisted of a newly refurbished lounge and dining area and a conservatory.

Since the last inspection the service had improved the recruitment processes to ensure only suitable staff were employed and staff were now receiving on-going supervision and dates for annual appraisals had been arranged.

Staff understood how to recognise and report abuse which helped make sure people were protected. People living at Chester House, a visiting relative and a healthcare professional spoken with all said they thought safe care and treatment was provided.

People had access to healthcare services and we saw specialist advice was sought in a timely manner, for example from the General Practitioner (GP), district nurse, dentist, optician and chiropodist. People were supported to attend hospital appointments as required.

Attention was paid to people's diet and people were supported to eat and drink in a way that met their needs. People living at Chester House were complimentary about the food provided and choices were available to people.

People were supported by a caring staff team and we saw that since the last inspection the home had employed the services of a permanent member of domestic staff, a part time activity coordinator, a part time gardener and a permanent cook. This meant there was more time for the care staff to spend with people.

A notice informing people how to make a complaint was displayed in the main entrance of the home and in the updated statement of purpose which everybody had recently been given a copy of. There was a system in place for receiving, handling and responding to concerns and complaints.

Since the last inspection improvements had been made to the systems used to monitor the quality and safety of the service. For example reviews of accidents and incidents had been carried out, along with a review of staff recruitment files, staff training and general cleanliness and infection control within the home. There was a monthly audit of all aspects of medication administration and regular staff and

resident/relatives meetings had been implemented. Staff told us that everything about the home had improved since the assistant manager had taken up post.

We saw that meaningful activities were provided based on people's personal preferences.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were appropriate systems in place for the effective ordering, control, management and administration of medicines.

The home was clean and personal protective equipment was available to staff to help reduce the risk of cross infection.

Appropriate checks had been undertaken to ensure suitable staff were employed to work with vulnerable people.

People told us they felt safe, and relatives told us they felt their relatives were safe in the home.

Is the service effective?

Good

The service was effective.

Staff members received an employment induction, regular supervision and training to help make sure people were provided with care and support that met their needs.

Where people were being deprived of their liberty the registered provider had taken the necessary action to make sure people's rights were considered and protected.

People enjoyed their meals and were supported to have enough to eat and drink.

People had access to external healthcare professionals, such as hospital consultants, specialist nurses, physiotherapists and General Practitioner's.

Is the service caring?

Good

The service was caring.

Staff were seen to be kind and caring in their interactions with people.

People looked content and well cared for.

A visitor spoken with told us they thought their loved one were well cared for.

Is the service responsive?

Good

The service was responsive.

All care plans had been reviewed and new documentation had been implemented which included details of what assistance the person required to meet their individual, assessed care needs.

We saw that people's needs were assessed prior to admission to ensure the home could meet their individual needs.

People were offered meaningful activities suited to their individual interests and preferences.

There was a system in place for receiving, handling and responding to concerns and complaints.

Is the service well-led?

Requires Improvement

The service was well-led.

At the time of the inspection there was no manager in post although there was an assistant manager in post.

There was clear leadership and structure in the home and the assistant manager had made positive improvements since the last inspection.

Staff had confidence in the assistant manager and the registered providers and felt well supported.

New systems had been implemented to monitor the performance of staff and the quality and safety of care provided. We will now monitor the sustainability of these improved systems to ensure good practice continues to be maintained.

The assistant manager and the registered provider understood their legal obligation to inform the Care Quality Commission of any reportable incidents that had occurred at the service.

Chester House Care Home

Detailed findings

Background to this inspection

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

This inspection was carried out over three days on the 27 and 28 February and 1 March 2017. Our visit on the 27 February 2017 was unannounced. The inspection team on the 27 February 2017 consisted of two adult t social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had knowledge and experience of dementia care and care homes in general. On the 28 February and 1 March 2017 the inspection team consisted on one adult social care inspector.

Before the inspection we reviewed all the information we held about the service. This included previous inspection reports, information provided by the providers following the last inspection. We also reviewed notifications that the provider is required to send to us. This is so the Care Quality Commission (CQC) can assess if appropriate action had been taken and the relevant people had been alerted in relation to certain incidents such as the death of service user, a safeguarding matter or a serious injury.

We sought feedback from Stockport Healthwatch, Stockport's local authority quality assurance team and the Control of Infection Unit. We had received positive feedback from Stockport's quality assurance team on several occasions since the last inspection and Stockport Clinical Commissioning Group (CCG) and the Control of Infection Unit shared their recent monitoring visit reports with us.. Information received was encouraging regarding the changes implemented by the assistant manager. We considered this information as part of the planning process for this inspection.

We did not ask the provider to complete a Provider information return (PIR) prior to the inspection on this occasion although we did receive a completed PIR in January 2016. 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.

During our visits, we spoke with the provider, the assistant manager, the cook, the domestic staff member, one senior carer, one member of care staff, a visiting health care professional, one visitor and four people living at Chester House Care Home.

We looked around the building including some bedrooms, all of the communal areas, toilets, bathrooms, the kitchen and the garden area.

We examined the care records for five people living at Chester Care Home. We reviewed a sample of medicine administration records, the recruitment and supervision records, training records and records relating to the management of the home such as the quality assurance systems.

Good

Is the service safe?

Our findings

At our last inspection in August 2016, we found a breach of the Health and Social Care Act 2008 (regulated activities) Regulations (2014) in relation to safeguarding people from abuse. At this inspection, we found improvements had been made and the requirements of the regulation were being met.
We saw there was now a system in place to record and audit any raised safeguarding allegations which would help identify any trends or lessons learnt. The assistant manager and the registered provider were aware of the appropriate action to be taken should an allegation of abuse be made and had copies of the harm level logs that would be sent to the local authority should a safeguarding incident occur or if an allegation was made. In addition they were aware of their responsibly to notify the Commission without delay if any allegations of abuse were made. This would enable us to assess if the appropriate action had been taken and the relevant agencies alerted. No allegations of abuse had been made since our last inspection in August 2016.

Staff we spoke with had an understanding of their role in protecting people and making sure people remained as safe as possible. Staff had access to a safeguarding adult's policy, which included all relevant contact telephone numbers, a copy of the local authority's multi-agency safeguarding adult's policy and an easy to follow flow chart for reporting suspected abuse.

We saw staff had access to a Whistle Blowing policy. The Whistle Blowing policy is a policy to protect an employee who wants to report unsafe or poor practice. All staff spoken with said they would feel confident to report poor practice.

People who lived at the home told us they felt safe. One person when asked said "I feel safe living here." Another person told us they felt safe and felt their belongings were safe.

The visiting relative that we spoke with said "I am incredibly impressed with the staff here. The girls are lovely."

A visiting healthcare professional we spoke with during this inspection told us they thought people living at Chester House were safe and well cared for. They said "I think this is a nice place."

At our last inspection in August 2016, we found a breach of the Health and Social Care Act 2008 (regulated activities) Regulations (2014) in relation to medication. At this inspection, we found improvements had been made and the requirements of the regulation were being met.

Since the last inspection we found the medication room had been reorganised and was tidier and more orderly. We looked at medication storage and found the storage cupboards were secure and they did not have excessive stocks of medication.

We saw a system was in place to record the temperature of the medication fridge and room temperature to ensure medication was stored at the correct temperature. Since the last inspection we saw the home had

purchased a room humidifier to ensure medication was consistently stored at the correct temperature so that the effectiveness of the medicines stored would not be compromised.

The home operated a Monitored Dosage System (MDS) for administering medicines. This is a system where the dispensing pharmacist places medicines into a cassette containing separate compartments according to the time of day the medication is prescribed.

We saw medicines had been checked on receipt into the home, administered as prescribed and safely stored and any surplus medicines were disposed of correctly. In addition we saw that medication such as prescribed creams had been brought forward from the previous month on the medication administration records. This meant there was an accurate recording of all medication stored in the home so an accurate audit could be undertaken to ensure people had received their medicating as intended by their GP.

People living at Chester House told us they received their medication on time. One comment was "I get my medicine on time." Another person told us they were given their medication and if they had any pain the staff would give them medication to help with the pain and reassure to them.

We saw that the assistant manager was in the process of introducing a laminated medicines safety summary sheet for each person. This recorded information about any allergies or intolerances, any observations needed when taking the medications and if the person had any swallowing difficulties. Once implemented this would help to minimise the risk of medicine errors.

We saw there were appropriate policies and procedures in relation to medication administration which staff had access to. Medicines were administered by care staff who had received appropriate training in storing, checking, administering medicines and disposal of medication. Care staff were not allowed to administer medication until they had received the appropriate training and had been assessed as competent. We saw all staff had received medicines awareness training and we saw certificates on their personnel files to confirm this training had been undertaken within the last six months.

Since the last inspection we saw that each person now had a 'my medications' plan of care. This included details of all medication prescribed, what the medication had been prescribed for, common side effects of the medication and specific instructions for each medication.

We saw that creams and ointments were prescribed and dispensed on an individual basis and each person had a 'topical administration record chart.' This also included a body map that clearly identified the name of the cream or gel, what it was being used for and where it was to be applied.

At the time of our inspection, we were told that no person using the service was administering their own medications and nobody was prescribed controlled drugs. Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs.

We saw that there were daily audits of medication administration and a daily stock balance of boxed or loose medication that was not included in the MDS system to ensure that people received their medication safely and as prescribed by their doctor. The assistant manager told us the daily audit was a short term audit process that would revert to a monthly audit in the near future when they were confident improvements made had been sustained.

At our last inspection in August 2016, we found a breach of the Health and Social Care Act 2008 (regulated

activities) Regulations (2014) because the registered provider did not have robust recruitment process in place to ensure suitable staff were employed. At this inspection we found appropriate improvements had been made and the requirements of the regulation were being met.

A recruitment and selection procedure was in place. We looked at thirteen employee personnel files and found that all of the staff members had been recruited in line with the regulations, including the completion of a disclosure and barring service (DBS) pre-employment check and at least two recent references from previous employers. Such checks help the registered provider and assistant manager to make informed decisions about a person's suitability to be employed in any role working with vulnerable adults. All staff members had been provided with an employee handbook which contained information about the home, policies and procedures and the expectations of staff. Where staff had been employed for a longer period of time, the assistant manager had created a DBS checklist to monitor when new DBS applications had been made and the date these checks were received. DBS checks return information from the Police National Database about any convictions, cautions, warnings or reprimands a potential employee may have and help employers make safe recruitment decisions and prevent unsuitable people from working with vulnerable groups. Although it is not mandatory that these checks are renewed, ongoing monitoring of staff DBS checks helps to ensure staff remain suitable to work with vulnerable people.

The registered provider and staff spoken with told us that after completing an employee application form, they were invited to attend a face to face interview to assess their suitability for the job. Following a successful interview the registered provider carried out the necessary pre-employment checks which included proof of the employee's identification (ID) and two references, one from a recent employer. In the thirteen staff recruitment records we looked at we saw evidence that staff members were not assigned any work until the appropriate ID, references and clearance from the DBS had been received and found to be satisfactory.

At our last inspection we found a breach of the Health and Social Care Act 2008 (regulated activities) Regulations (2014) because not all safety checks had been undertaken to help keep people safe and there were shortfalls in relation to infection control. At this inspection, we found improvements had been made and the requirements of the regulation were being met.

We reviewed the safety certificates for the building and found all relevant safety and maintenance checks had been carried out, and safety certificates were in order. This meant that the building and the equipment including the stair lifts and moving and handling equipment were well maintained and safe to use. For example we saw evidence of gas and electric safety certificates, Legionella testing, stair lift and hoist servicing and portable appliance testing (PAT).

Since the last inspection we saw the implementation of daily safety checks for example fire exits, fire extinguishers, any flooring hazards and checks of waste bins and the garden area. In addition there were monthly safety checks and risk assessments which included checks of the window restrictors, the nurse call bells, electronic door guard checks, showerhead disinfection and water temperature delivery testing. This was to ensure people were safe and were not at risk of scalding. We saw that all free standing wardrobes were secured to the wall to minimise the risk of injury to people.

Risk assessments were in place and covered areas such, nutrition which included swallowing difficulties and the risk of choking, moving and handling, skin care and the risk of falls. These provided information to staff on how to manage identified risks. For example, a nutritional risk assessment would identify if somebody was at risk of malnutrition. We saw environmental risk assessments had been undertaken of the premises which would help mitigate potential risk to people using the service and to staff and visitors to the home.

In addition to the daily safety checks monthly checks were also undertaken of the fire extinguishers, emergency lighting, emergency exits and fire alarm checks were being carried out. There was an emergency evacuation procedure and everybody had a Personal Emergency Evacuation Plan (PEEP). These plans detailed the level of support the person would require in an emergency situation. There was a floor plan in the main entrance of the home and a PEEP's summary was kept here should they be needed in an emergency situation. Since the previous inspection we saw a fire drill policy had been put in place which stated a fire drill would be undertaken every six months. We saw a fire drill exercise had been undertaken on 2 January 2017 and 19 February 2017. This meant in the event of an emergency evacuation, staff would be able to effectively evacuate the home and any risk to people being evacuated would be reduced.

We saw the staff rota did not clearly identify the first aider working on each shift in case of a first aid emergency. However the assistant manager assured us this would be implemented. This meant it would be clear to all staff on duty who the first aider on shift was and they would lead any emergency situation should one arise.

We looked around the home, at all the communal areas, toilets, bathrooms and a sample of bedrooms on each floor. During the inspection, we looked around the kitchen and the food storage area. We saw that the kitchen was clean and there were adequate supplies of food. We saw that appropriate safety checks had been undertaken. For example fridge and freezer temperatures were recorded and there was a daily cleaning schedule for the kitchen. However it was noted that although deep cleaning was being undertaken there was not a schedule in place for that cleaning in the kitchen. For example cleaning the inside of the cooker, the extractor fan, the kitchen walls and inside the kitchen cabinets. Following the inspection we were sent a copy of a 'kitchen deep clean monthly checklist that had been implemented. We saw colour coded chopping boards and separate meat knifes were in use to reduce the risk of cross contamination. We also saw that all opened food in the fridge was covered and had a recorded date of opening to ensure that people were not put at risk of eating out of date food.

Since the last inspection some refurbishment had taken place. For example we saw the lounge and dining room had been redecorated, new light and light fittings had been fitted, new curtains, two new lounge chairs and all new dining room chairs had been purchased. We saw the conservatory had a new carpet and the ground floor corridor and been redecorated and had a new carpet. In addition new bed linen had been purchased which included new quits and quilt covers that had been chosen to suit the individual taste of the service user. One bedroom had also been completely redecorated.

Since the last inspection the home had employed the services of a part time domestic who worked four hours a day over six days. On the seventh day care staff assumed the responsibility of maintaining the cleanliness of the home. Care staff spoken with said the employment of the member of domestic staff was a great help and freed them up to spend more time with the people living at Chester House.

All bathrooms and toilet areas were clean and contained wall mounted liquid soap and paper towel dispensers. We saw that cleaning schedules were in place and these were updated during the inspection to clearly evidence the cleaning undertaken and by whom. We saw in the communal bathrooms and toilets evidence that an hourly check was undertaken to ensure a high standard of cleanliness was maintained.

We saw an infection control policy that was accessible to staff, which helped the staff to maintain good infection control practices in the home.

During our inspection, we saw personal protective equipment (PPE) such as disposable aprons and gloves were available throughout the home as was hand sanitiser, which would help reduce the risk of cross

infection.

We saw the use of colour coded mops for cleaning and good stocks of cleaning products which helped staff to maintain good standards of hygiene and cleanliness throughout the home.

All cleaning products were stored in a locked room to ensure people's safety. Substances Hazardous to Health (COSHH) safety data sheets had been obtained for the for the cleaning materials used in the home and a copy was kept in a file that was accessible to staff. COSHH is the regulation that requires employers to control substances that are hazardous to health.

Stockport's local authority Health Protection and Control of Infection Unit had undertaken an audit in May 2016 and a re-audit in November 2016. No major issues had been identified.

At our last inspection in August 2016, we found a breach of the Health and Social Care Act 2008 (regulated activities) Regulations (2014) because there was not a systematic approach to determine the number of staff and range of skills required to meet the needs of the people who used the service. At this inspection, we found appropriate improvements had been made and the requirements of the regulation were being met.

We saw that people's dependency levels were assessed on a monthly basis to ensure there were sufficient staff on duty to meet people's assessed needs.

From looking at the staffing rotas and speaking with the assistant manager we saw staffing levels in the home consisted of two care staff on duty at all times. During the day one of those care staff were a senior carer and we were told it was the intention of the assistant manager to ensure a senior cares was also on duty overnight. In addition to the care staff on duty we were told that one of the providers or the assistant manager would also be in the home. During the last inspection we were told that as part of the hours worked care staff were expected to clean the home, undertake the laundry and cook and serve the meals. Since that inspection a domestic member of staff had been employed and a cook had been employed, allowing care staff to spend more time with residents.

Good

Is the service effective?

Our findings

At our last inspection in August 2016, we found a breach of the Health and Social Care Act 2008 (regulated activities) Regulations (2014) because staff were not receiving support, supervision and appraisal. At this inspection, we found improvements had been made and the requirements of the regulation were being met.

Since the last inspection we saw an ongoing annual staff appraisal and supervision system had been implemented. The system was used at regular intervals to discuss and evaluate the quality of staff member's individual performance and where best practice or practice improvement were discussed and recorded. This system was also used for any agency staff employed at Chester House. Staff we spoke with confirmed they received regular supervision at least every three months and an annual appraisal. We examined thirteen staff supervision records, which showed the dates individual staff supervision sessions had taken place and the dates of sessions planned in advance. Supervision meetings provide staff with an opportunity to speak in private about their training and support needs as well as being able to discuss any issues in relation to their work.

Staff had undertaken a full employment induction before starting work at Chester House. Records showed they were given a seven day mandatory induction that covered topics such as, safe handling of medication, fire evacuation, risk assessments, safeguarding, whistle blowing, and control of substances hazardous to health (COSHH)..

This induction was followed by a period of shadowing (working under the supervision of an experienced staff member) within the home. This gave the new staff member the opportunity to get to know the people who used the service. A probationary period of three months was in place for new staff, this could be extended if required. Non care workers, such as kitchen and domestic staff, underwent a similar induction period and learning was specific to their job. Additional induction training would be provided via the Care Certificate for new staff. This is a professional qualification that aims to equip health and social care staff with the knowledge and skills they need to provide safe and compassionate care. This meant staff members had received appropriate training to help make sure people received safe and appropriate care.

Additional e-learning was available in topics such as, dementia awareness, basic life support, falls prevention and infection control. The registered provider told us that training would be arranged for staff where it was identified specialised knowledge would help to meet people's specific health and treatment needs. This was confirmed when we examined the care records of people who displayed challenging behaviour. The registered provider had liaised with the community mental health team (CMHT) to seek further advice and further staff training in this topic.

When we spoke with people living at Chester House they were complementary about the staff and their ability to provide them with care and support. People said, "They [staff] are very nice. They help us a lot."

It was apparent from speaking with staff that they had a good understanding of how and why consent must

be sought to make decisions about specific aspects of people's care and support and we observed staff obtaining verbal consent from people during our inspection. For example at lunch time, we observed staff asking if people would like to come to the dining room for lunch and then asked people what they would like to eat. Staff also talked about the importance of getting to know people and how they liked things to be done.

We looked at what consideration the provider gave to the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. This legislation sets out what must be done to make sure the human rights of people who may lack mental capacity to make decisions are protected. The Deprivation of Liberty Safeguards (DoLS) provides a legal framework to protect people who need to be deprived of their liberty to ensure they receive the care and treatment they need safely and where there is no less restrictive way of achieving this.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered provider, assistant manager and staff were knowledgeable about the MCA and the need to carry out mental capacity assessments for people who required them. Where a mental capacity assessment had been completed we saw that best interest decisions were recorded including any consultation undertaken and a rationale for reaching the decision made. We examined a person's 'Plan of Care Required In: Maintaining A least Restrictive Deprivation Of My Liberty'. The plan clearly described what the person would like to achieve, the reasons preventing the person from improving/ maintaining their wellbeing and support required whilst subject to DoLS. This meant the person was being supported to receive the care and treatment they needed safely in the least restrictive way.

During the course of the inspection a DoLS tracker document was implemented which included details of when the DoLS request had been made, when it had been authorised and when it was due to expire. This meant there was a central list that acted as a reminder to seek renewals when necessary.

The assistant manager was in the process of implementing a document to record where a person had appointed a Power of Attorney (POA) to act on their behalf and obtained copies of the original documents. A POA is a way of giving someone you trust the legal authority to make decisions on your behalf in relation to health and welfare or finances if you lack mental capacity to make decisions for yourself.

Staff told us they communicated well with each other and staff handover meetings were held at the start of each shift. In addition there was a written handover sheet and a communication book available for staff to look at. This helped to ensure that staff were given an update on a person's condition and behaviour and ensured that any change in their condition had been properly communicated and understood.

The service supported people with varying levels of support needs ranging from people being able to mobilise around the home to requiring more support in areas such as eating and drinking. People's nutrition and hydration was considered and monitored to ensure their needs were being met. Care records and daily records examined showed attention was paid to people's dietary requirements and what they ate and drank. We saw some people required a pureed or softened diet and were served these meals and this was

documented in their care records. Staff were aware of the need to follow the speech and language therapist (SALT) instructions. For example making sure that people at risk of choking received a pureed diet. SALT provides treatment support and care for people who have difficulties with communication or with eating, drinking and swallowing. Staff spoken with were knowledgeable about people's dietary and nutritional risks.

We saw a daily menu was on display outside the kitchen which people were looking at throughout the inspection and discussing with each other. We saw that staff asked people what they would like to eat and people's preferences were accommodated.

We spoke to the cook who had a good understanding of people's personal dietary preferences, including their likes, and dislikes. The cook confirmed that a variety of meals were provided if people did not want what was on the menu.

The people we spoke with told us there was enough food to eat. A visiting relative we spoke with told us that people were given individual meals of their choice. We saw that juice and a choice of snacks for example biscuits, cake and fresh fruit were available for people to access in the lounge/ dining room.

People had choices about what they wanted to eat and we saw where required, they were assisted to eat or supported to eat their meal with prompts from staff. Dining tables were set for each meal time and where people preferred to eat in their rooms or in the lounge area, they were supported to do so. We saw the meals served were well presented, looked appetising and nutritionally balanced.

People who used the service told us that the meals served at Chester House were good and they had a varied choice of food. For example during the inspection we heard a member of staff asking people how their lunch tasted and if they had enjoyed their meal. People responded positively and made comments such as, "This is lovely, very tasty" and "Yes mine is very good, thank you".

Care records showed people had access to external healthcare professionals, such as hospital consultants, district nurses, dieticians, community mental health workers and GPs, and the notes of their visits were included in people's care plans. Other care files showed attention was paid to general physical and mental well-being, including risk assessments to identify where people were at risk of poor skin integrity or had specific mental health needs. Care records that recorded people's weight, dental and optical checks were also in place and people were supported to attend hospital and doctor appointments.

When we walked around the home we saw sufficient and suitable equipment in place to promote people's mobility such as handrails and wheelchairs. The service maintained a homely environment to enable people's planned activities and routines to be supported effectively by staff members.

Good

Is the service caring?

Our findings

We observed staff interactions with people and we saw they were good at respecting people's privacy and dignity and the relative we spoke with confirmed this. For example we saw a service user come into the lounge in their nightwear who was clearly quiet distressed. A member of staff immediately approached them and asked discreetly if they would like a shower and their hair washed. The person then appeared much calmer and went with the member of staff for a shower. We observed staff discreetly ask people if they required the toilet and we saw that doors were closed to ensure privacy if personal care was to be delivered.

We saw that privacy and dignity training had been undertaken by staff in December 2016, as part of the training the staff had participated in role play in an attempt to help them see things from the perspective of the person receiving care.

During our inspection we saw staff were attentive to people's needs, responding to people and their requirements throughout the day. People who required a high level of support received care that was responsive and person centred, such as assistance at meal times. We saw some people were not able to tell staff when they needed assistance and relied on staff being attentive, listening to them and recognising their needs. For example offering regular drinks and snacks to maintain hydration and nutrition and offering toilet assistance where required.

The people we spoke with who were living at Chester House Care Home told us they were very happy and felt well cared for. One person said, "Staff are very helpful if you need something. They go out of their way." Another comment was "There is always someone to speak to, the staff are busy but they have time to speak."

One healthcare professional said they thought Chester House Care Home was a good home and feedback they had received from one of the visiting relatives was that they were very happy with the care provided.

We saw that people were all well-groomed and appropriately dressed. Staff were observed to demonstrate a good knowledge of the people who used the service and their individual personal preferences. The atmosphere felt relaxed and people who were able were seen to be freely moving around the home. People looked comfortable and content in their surroundings and in the company of staff.

We saw that staff were kind, patient and respectful in their interactions with people. We observed one person say they were cold so a carer immediately brought them a cardigan and helped them put it on. We heard another carer patiently assisting and encouraging a person to walk into the lounge without rushing them.

We saw the provider help settle a person into the lounge by offering them a newspaper to read and adjusted the water feature so that the person could watch the artificial fish moving, which they clearly enjoyed doing.

We saw another person come into the dining area asking for some breakfast. The provider immediately respond by asking what they would like for breakfast. They then sat chatting with them until another carer came to assist with breakfast.

Information was present in people's care records about their individual likes and dislikes, hobbies and interests. For example, preferred retiring and getting up times and what their hobbies and interest were. This personalised information helped staff to provide care and support based on people's personal preferences. Information on people's lives and work life was recorded in people's care records to help staff better understand the individual.

Care plans contained information in relation to supporting effective communication with individuals. This included information on any communication aids such as glasses or hearing aids that the person might require to help them engage in conversations and activities.
Care interventions were clearly recorded on the person's daily record sheet and detailed the care and support provided to people during the day. Staff members were aware of the importance of the care review system and understood information about the person was reviewed to make sure it fully reflected their current support needs.

The assistant manager told us that at the time of this inspection nobody was receiving End of Life care but it was a service they would provide.

The assistant manager told us that no one using the service was currently using the services of an advocate although details of local services were available on request. An advocacy service provides an independent advocate who is a person who can help access information on a person's behalf and / or represent a person's wishes.

We saw that people's belongings were treated with respect and staff only entered a bedroom if they had the permission of the person . When we looked in bedrooms, we saw that a high standard of cleanliness was maintained, and clothes were hung appropriately in wardrobes.

Information held about people who used the service was locked in a secure room when not in use to maintain confidentiality.

Good

Is the service responsive?

Our findings

At our last inspection in August 2016, we found a breach of the Health and Social Care Act 2008 (regulated activities) Regulations (2014) because we found that some identified care needs did not have a corresponding plan of care to meet that care need and meaningful activities were not actively promoted for people. During this inspection we found significant improvements had been made and the requirements of the regulation were being met.

Since the last inspection we saw that people had been asked about what activities they would like to do and what hobbies or interests they had. We saw that some had said they liked planting bulbs and enjoyed sitting in the garden. In response to this new garden furniture had been purchased ready for people to enjoy when the weather improved. We also saw that some people had planted bulbs and flowers in pots ready to go outside in the warmer weather. One person was very excited to tell us that they were in the process of planning a party to celebrate the number of years they had lived at Chester House. We saw that activities had been discussed at the 'residents meeting' held in December 2016 and they had decided they would like a trip to Manchester airport so plans for this were underway. Each person had a record of activities that had been undertaken. For example going shopping, nail painting and pedicures, hand massage, board games and singing and dancing. In addition we saw the home employed the services of monthly outside entertainers and had recently held a fashion show which the assistant manager told us people had really enjoyed.

A visiting relative told us that their loved one had a special riser chair which they liked to sit in while listening to a CD and they were pleased to see that staff were facilitating this on a regular basis for them.

Since the last inspection the home had recruited the services of a part time activities coordinator and during our inspection we saw another activity coordinator visited the home for a trial session with a view for some part time work. Following their visit we saw one person was particularly animated and had thoroughly enjoyed one of the sessions provided.

We saw people's needs had been assessed before they moved into Chester House. This information helped to ensure the home could meet the individual assessed needs of the person. The pre admission needs assessment was used to help complete the care plan which enabled the person to be cared for in a person centred way. Records showed staff used the information to develop the care plans and support records that identified people's abilities or the support required to maintain their independence. Systems to help manage / prevent risks were in place. For example in one care plan we examined we saw there was an assessment of self-care and activities of daily living skills record. This record highlighted risks using a traffic light system to indicate the level of risk, such as green no risk, amber low to moderate risk and red indicated there was a high to major risk which required constant observations. Where care plans identified people were at risk of pressure sores specialist equipment such as pressure relieving mattresses and pressure relieving cushions, were in place. Where people's support needs were identified as requiring two members of staff, the reasons why were clearly documented. This helped to make sure people's health and wellbeing was appropriately responded to and maintained.

The assistant manager said they had not had any admissions to the home since the last inspection, but people interested in living at Chester House Care Home would be encouraged to have a look round the home and would be invited to visit the home, have lunch and meet the staff and other people living at the home before they made a decision about moving in. A visiting relative confirmed this and told us that their relative had spent half a day at the home prior to the decision being made for them to move in.

Since the last inspection we saw people's care files had been reviewed and new documentation had been implemented. We looked at the care files for five people who lived at the home. The care files were neat, orderly and easy to use and contained good information about each person and sufficient detail to guide staff on the care and support to be provided. Care records included the person's emergency contact details such as their next of kin, and General Practitioner (GP). We saw an activities of daily living assessment to identify people's individual care needs, risk assessments, current support needs, the care to be provided and the desired outcome from the care provided were in place. Records contained relevant information about people's individual needs and future goals, people's health diagnosis and associated needs, nutrition and hydration assessments that included information about sleeping, behaviour, recent weight loss, appetite, difficulties chewing or swallowing, mobility assessments, moving and handling and tissue viability. We saw people's care and support records were clear, detailed and completed accurately to reflect the care and treatment provided. People's weights were recorded monthly or more frequently if necessary. A body map to record and highlight any bruising or injuries sustained, was kept in the persons care record. Assessments showed people had been involved in the assessment process wherever possible.

We saw care plans in place to meet people's assessed care needs such as communication, breathing, eating, drinking, skin integrity, mobility, personal hygiene, capacity, advanced decisions and end of life care, required staff to seek further support from appropriate outside agencies, such as SALT or district nurses, should any of these areas develop into risks.

Care plans were reviewed monthly or more frequently if the person experienced any health changes and contained clear guidance for staff to follow. This meant staff could respond in a timely way to help make sure people's health and wellbeing was maintained.

During our discussions with the registered provider, assistant manager and staff we found they were aware of people's individual care needs, preferences, likes and dislikes around their daily lives and the importance of this. Staff were able to give very specific examples of people's personal preferences and how they liked to spend their day. For example one person liked to say in bed late in the morning and then come downstairs for a late breakfast in the dining room.

A visiting relative we spoke with was very positive about the care provided at the home and they told us they liked the family atmosphere and the friendship that staff demonstrated towards people. They confirmed that they had seen their relative's plan of care and were happy with its content.

Some staff comments were: "It feels more like a family now, this is a happy home" and "We know people as individuals and there is a lot of choice, it's just like us at our own house there is no set routine." We saw evidence of this during our inspection. For example we saw people come downstairs late because they had wanted a lie in bed and we saw somebody request a shower in the afternoon and have their hair washed and blown dry.

During our inspection we heard staff and people living in the home communicating well with each other and we saw people freely expressing their needs. We saw that staff responded appropriately in supporting people.

Since the last inspection we saw that the statement of purpose had been updated and we were told that each person had been given a copy. The statement of purpose included key names and contact numbers, the organisational structure of the home, the aims and objectives of the home, a philosophy of care and information regarding the facilities available including meals, the complaints procedure, plus other relevant information for people who lived at the home and people who may be considering moving to the home needed to know. In addition there were information brochures available on request for people with information about the service provided.

A copy of the complaints procedure was on display in the main entrance of the home and in the updated statement of purpose.. The procedure explained who to contact should they need to raise a complaint and the timescales for action in response to the complaint.

All of the people we spoke with told us they had never made a complaint but would do if they had any concerns. The assistant manager told us they made themselves available and encouraged people to raise any issues or concerns at an early stage individually or at the resident and relatives meetings so they could be swiftly dealt with.

We looked in the complaint file and saw no complaints had been recorded since the last inspection.

Requires Improvement

Is the service well-led?

Our findings

A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. Since our last inspection the registered manager had left the service so there was no registered manager in post. The home was currently being jointly managed by the two registered providers, who are both registered nurses and an assistant manager who had recently qualified as a doctor.

People living at Chester House Care Home told us they were happy living at the home and happy with the care they received.

All of the staff we spoke with were positive about the current management arrangements at the home. One member of staff said "Recently things are much improved and the residents are much happier. The atmosphere is happier and residents are more settled, this is a lovely place to work." Another member of staff said "There have been massive improvements in every way. The décor is much better, the documentation has improved, the training has improved, there are more activities for the residents, we are now included in the decisions made, we have more staff and we are more supported."

The staff were welcoming on our arrival and the atmosphere felt calm and relaxed. The visiting healthcare professional said they had always been made to feel very welcome.

At our previous inspection in August 2016, we found a breach of the Health and Social Care Act 2008 (regulated activities) Regulations (2014 because we found the registered provider had failed to establish and operate effective systems to assess, monitor and improve the quality of the service. At this inspection, we found significant improvements had been made and the requirements of the regulation were being met.

There had been systems put in place to monitor the quality and safety of the service delivered, this included audits of all key functions of the home including falls, complaints, mattress cleaning, staff training, staff personal files, medication management, peoples care files, general cleanliness and accidents and incidents. This meant the registered provider had implemented effective systems to assess, monitor and improve the quality of the service.

The assistant manager told us they were in the process of implementing an annual infection control audit to ensure the high standards of cleanliness had been maintained and to identify any areas of possible improvements.

At our last inspection in August 2016, we found a breach of the Care Quality Commission (Registration) Regulations 2009. Part of a registered provider's and registered manager's responsibility under their registration with the Care Quality Commission (CQC) is to have regard to, read, and consider guidance in relation to the regulated activities they provide, as it will assist them to understand what they need to do to meet the regulations. One of these regulations relates to the registered provider's/ registered manager's

responsibility to notify us of certain events or information. At the last inspection we found that the registered provider/ manager was not sending us the required notifications. Since the last inspection the registered provider had been notifying us of required events and information.

Since the last inspection the assistant manager had reviewed all the policies and procedures and staff were able to access hard copies of these as well as on line access. This meant that staff had access to up to date good practice guidance.

The assistant manager had also arranged regular meetings for relatives to attend. We saw minutes of a meeting held in December 2016 to inform relatives that the registered manager had left employment, the CQC inspection report and the quality rating. The assistant manager told us that all relatives who were not able to attend the meeting had been contacted individually to discuss the content of the meeting. We also saw minutes of a meeting held in January 2017 to discuss the new care plan documentation and the implementation of the 'my life story' documents. The registered provider and the assistant manager told us they encouraged relatives/visitors to speak with them about any issues they had or wished to discuss and we saw they made themselves readily available.

The assistant manager had also arranged staff meetings and staff spoken with confirmed this. The assistant manager said that on a short term basis it was their intention to have monthly staff meetings and staff were encouraged to speak to any of the management team with any issues they had. Minutes of the meeting demonstrated that the current management arrangements of the home and the last CQC inspection report and the quality rating had also been discussed with staff. Staff told us that they felt supported by the management team and felt they could approach them at any time.

The assistant manager was aware of the importance of seeking feedback from people using the service, their families and visiting healthcare professionals. An independent professional during December 2016 and February 2017 had visited the home and undertaken a 'resident questionnaire' to obtain objective feedback from people living at Chester House. We saw one comment from a person using the service was that they would like to have fresh fruit available at all times. During the inspection we saw that this comment had been actioned and fresh fruit was readily available.

We saw that 'quality of service questionnaires' had been given out to relatives in November and December 2016 and February 2017. The returned results had been analysed and the results had been discussed at the relatives meeting. Some of the comments from the survey included: "I continue to be impressed with all the caring staff and the cheerful atmosphere created." "I have nothing but praise for everyone at Chester House" and "The staff have always been welcoming and friendly."

'Quality of service questionnaires for visiting professionals' had been given out from November 2016 to February 2017. Seven questionnaires had been returned and some comments included: "Staff are great and really helpful, they are interested in what I am doing and how they can help. They seem to really care." Another comment was "The home does not smell at all and all the residents that I visit are always immaculate" and "I have no complaints to make."

In addition we saw a comment box situated in the main entrance to the home so anybody living or visiting the home could provide comments or suggestions about the service provided. This demonstrated that people were encouraged to give feedback about the service.

We observed throughout our inspection that the registered provider and the assistant manager were visible within the home, interacting with people, their relatives and a visiting health professional.

We saw people living at Chester House, relatives and visitors to the home approach the registered provider and the assistant manager with ease and without hesitation.

Although we saw improvement had been made, we have not rated this key question 'good', to improve the rating to 'good' would require a longer term track record of consistent and sustainable good practice.