Chalkney House Ltd

Chalkney House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**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 took place on 10 and 11 September 2018 and was unannounced.

Chalkney House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service accommodates 47 people in one adapted building. At the time of our inspection there were 37 people using the service.

There is a registered manager in post. 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.

Our previous inspection on 3 February 2018 found eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to the management of medicines and failure to identify and manage risks to people using the service. Infection prevention and control policies were not always followed by staff and cleaning schedules were not being used effectively to keep the premises clean and odour free. We also found that people's nutrition and hydration needs were not always being properly managed. People's care plans were not always person centred, completed or reflective of their current needs. Staff lacked guidance on how to respond to people on end of life care to ensure they were pain free and comfortable when they died. People lacking capacity were not consistently supported in line with the requirements of the Mental Capacity Act (MCA) 2005 legislation. Systems to assess and monitor the service were not being used effectively to identify where improvements were needed. Complaints had been investigated however, the outcome and judgements made were not always open and transparent or used to improve the quality of the service.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when. At this inspection we discussed the action plan with the registered manager and what progress had been made. Improvements had been made to the management of medicines. However, there continued to be failure to identify and manage risks to people using the service. People's, Personal Emergency Evacuation Plan (PEEP) were not always correct, which meant staff did not always have accurate information to provide the right level of support to keep people safe. Additionally, assessments to mitigate risks to people were not consistently followed by staff, specifically in relation to prevention of falls. Falls resulting in head or facial injuries were not being well managed.

We found ongoing issues with regards to cleanliness and unpleasant odours in the service. Although there was sufficient staff on duty to meet people's needs and keep them safe, we found the contracted hours for domestic staff were not sufficient to keep the premises clean. The systems in place to monitor the quality of the service, were largely a tick box process and were not effectively used to identify where improvements were needed. For example, these had failed to identify the lack of cleanliness and poor quality of bedding

we continued to find. The quality of bedding had been raised at our previous inspection and whilst immediate action had been taken to purchase more, there was no regular checks taking place to ensure bedding was fit for purpose.

Record keeping had improved. The provider had introduced an electronic care recording system which provided good details about the food and drink people received to ensure their nutrition and hydration needs were being met. A 'Resident of the week' initiative had been implemented and was helping to improve care plans and ensured people received person centred care that was specific to them. Documentation in relation to people's mental health and other conditions such as dementia that affected their wellbeing had improved and staff had a better understanding on how to support people at times of anxiety.

The arrangements for people nearing the end of life care had significantly improved. Measures had been put into place that ensured people received a dignified, comfortable and pain free death. People's families had confirmed this with positive feedback directly to CQC and via thank you cards to the staff.

One complaint had been received and investigated in full since our last inspection. This had been responded to in a transparent way, involving other agencies to find an appropriate solution to the concerns raised.

Staff demonstrated a good awareness of safeguarding procedures and knew who to inform if they witnessed or had an allegation of abuse reported to them. A thorough recruitment and selection process was in place, which ensured staff recruited had the right skills and experience and were suitable to work with people who used the service.

Where a missing controlled medicine had been identified the registered manager had taken immediate action and reported this to the appropriate authorities. They had investigated, and arranged for a review of medicines by an external pharmacist to learn what went wrong. Following their recommendations, the registered manager had implemented measures to prevent this happening again, including retraining all staff.

Staff received training to meet the specific needs of people using the service and relevant to their roles. New staff were mentored by an experienced member of staff until assessed as competent to work unsupervised. Staff were supported and received regular supervision regarding their performance.

People were supported to have maximum choice and control over their lives and staff supported them in the least restrictive way possible, the policies and systems in the service supported this practice. People's care plans clearly documented how decisions about their care or support were made where they lacked capacity. Where decisions were being made on people's behalf their family representatives and/or professionals were involved in making decisions that were in the best interests of the person.

Mealtimes were a positive experience for people. People were complimentary about the food. Staff were aware of people's dietary needs, and followed professional advice where people were identified at risk of weight loss or choking. People had access to a range of healthcare services, such as the dietician, Speech and Language Therapist (SALT), district nurse, continence nurse and the community mental health team.

People and their relatives were complimentary about the attitude and capability of the staff. Staff were kind and caring and had developed good relationships with people. People told us they were supported to make choices and decide how they spent their day. People were treated with dignity, respect and kindness.

People had access to a range of activities, within the home and via external sources, and chose if they wanted to take part.

People, their relatives and staff spoke positively about the registered manager. Staff felt supported by the registered manager. They described them as approachable, very hands on, supportive and demonstrated good leadership, leading by example.

The registered manager had sought feedback from people using the service, their families, the public and staff about the quality of the service provided. Questioners, resident meetings and reviews of the service on the internet, provided positive feedback.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Systems to assess and respond to risk, were not always consistently applied or managed to protect people from harm, or the risk of harm occurring.

Staff understood their responsibilities to raise concerns, and demonstrated a good awareness of safeguarding procedures, how to recognise and report signs of neglect or abuse.

There were enough staff to meet people's needs, but insufficient domestic staff hours to keep the premises clean.

Systems for recruiting new staff were carried out safely to ensure potential employees were suitable to work at the service.

People's medicines were managed consistently and safely.

Is the service effective?

Good

The service was effective.

Staff had good access to training to ensure they had the skills and knowledge to carry out their roles and meet people's needs.

People were supported to have choice and control over their lives and staff supported them in the least restrictive way possible.

People were happy with the meals provided and were provided with enough to eat to maintain a balanced diet.

People received support to maintain their health and had access to appropriate healthcare services.

The requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) were understood. People were supported to have maximum choice and control over their lives and staff supported them in the least restrictive way possible.

Is the service caring?

Good

The service was caring.

People's privacy and dignity was respected was maintained.

Staff were kind and caring and had developed positive relationships with people using the service.

Staff had a good knowledge of what people could do for themselves, how they communicated and where they needed help and encouragement.

People were supported to make choices and decide how they spent their day.

Is the service responsive?

Good

The service was responsive.

People's care plans were reflective of their current needs. A 'Resident of the week' initiative ensured people were receiving person centred care.

Complaints were investigated and responded to, in a timely manner.

People were provided with the support they needed to experience a comfortable and dignified pain free death. The registered manager had consulted with other healthcare professionals to ensure proper systems were in place to provide palliative care. Staff were knowledgeable about how to support people well at the end of their life.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People, their relatives and staff spoke positively about the registered manager. Staff felt supported by the registered manager.

Systems used to monitor the quality and safety of the service were not effective.

Chalkney House

Detailed findings

Background to this inspection

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

This inspection took place on 10 and 11 September 2018 and was unannounced. The inspection was carried out by two inspectors, on both days.

Before the inspection we reviewed information available to us about this service. The registered provider had completed a Provider Information Return (PIR). This is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information provided in the PIR and used this to help inform our inspection. We also reviewed previous inspection reports and the details of complaints, safeguarding events and statutory notifications sent by the provider. A notification is information about important events which the provider is required to tell us by law, like a death or a serious injury.

We spoke with five people who were able to express their views, but not everyone chose to or were able to communicate effectively or articulately with us. Therefore, we used the Short Observational Framework for Inspection (SOFI) which is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with one relative who was visiting their family member on the second day of the inspection. We also spoke with two care staff, the head of care, the chef, the registered manager and an area manager for the company.

We looked at five people's care records, three staff files and reviewed records relating to the management of medicines, complaints, staff training, records in relation to maintenance of the premises and equipment and how the registered persons monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in February 2018, we found arrangements for the prevention and control of infections did not protect people from the risk of harm, or ensure that the premises were clean. The providers action plan provided following the last inspection identified that new cleaning schedules had been introduced and regular audits of infection control practices and cleaning were being undertaken. At this inspection, although we saw some improvement, we continued to find areas of the service that were unclean. People's rooms had food waste on the floor and unpleasant odours were identified in parts of the service. Two people's bedrooms had an odour of urine and in another person's room we saw faeces on the floor and arm chair. Floors, beds and bedding in people's rooms were not being cleaned to an acceptable standard. For example, one person's bottom sheet on their bed was stained with blood and faeces. During the inspection we observed a person urinate on the carpet in the hallway, near the reminiscence room. This went unnoticed by staff, who walked passed the area, on at least four occasions. We had to bring their attention to this before the carpet was cleaned to prevent staining and odours occurring. One person's relative told us, "There is the occasional odour, but I am aware this is due to the nature of the people living in the home, I think they do their best to keep the home clean."

We looked at the daytime domestic cleaning schedules, which covered bedrooms, bathrooms and toilets. Communal areas, wheelchairs and hoists were allocated to night staff. The cleaning schedule was broken down into daily, weekly and monthly tasks. Daily tasks consisted of making beds, cleaning toilets, sinks, hand gel and soap dispensers, mopping and hovering the floor, dusting cobwebs and polishing, emptying bins, checking hand towels and toilet rolls. Weekly and monthly tasks, included a more in-depth clean of windows, skirting boards and walls. At the time of the inspection there were 37 people in residence. The duty roster showed two domestic staff were employed weekdays from 7-1, and one at weekends, from 8-1 to complete these tasks. Weekdays, there was a total of 12 domestic hours, divided between the 37 rooms, which meant there was approximately half an hour for each room to do all the daily tasks, plus the additional weekly, and monthly tasks. On the first day of the inspection one domestic was on annual leave and had not been covered on the roster. The second domestic due to unforeseen circumstances had taken special leave. This left no domestic staff on the premises. The registered manager told us care staff would cover this during the shift. However, a member of staff told us, "We don't do cleaning, that's down to the domestic staff. Both cleaners are off today. Some of the carpets smell. We have said many times there are not enough domestic staff. This is a big home, we don't have time to clean. There is only one cleaner at weekends, so carers have to make beds." On the second day additional care staff had been rostered to clean the premises.

We also found the condition of people's bedding was poor, sheets were thin, and in some cases almost transparent. People's pillows were lumpy and stained. Some people's duvets had no covers, and on one person's bed there was no duvet, just the cover. One person told us, "My bed is comfortable, but I can't make out why its covered in plastic, when its warm, I get very hot and when I roll over I feel it. I only have two pillows, but I would like three, they are not very comfortable." This was discussed with the registered manager who immediately ordered new bedding.

This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Our previous inspection identified individual risks to people had not been consistently assessed or managed to protect them from harm or the risk of harm occurring. This had included incorrect information in people's Personal Emergency Evacuation Plan (PEEP). Outside people's rooms was a framed photograph to help them identify their room. The frames were colour coded and reflected the level of risk identified in their PEEP and were a quick guide for staff if they needed to evacuate people quickly. However, the PEEP folder, only contained 36 plans, one person was not accounted for. Their details were also missing from the fire evacuation plan. Additionally, two room numbers did not match the occupants, as listed on the fire grab sheet at the front of the PEEP folder. This incorrect information meant the risk was not properly assessed and in the event of an emergency the existing information (and colour coded frame) would not guide staff to provide the right level of support to keep these people safe. Additionally, the fire evacuation plan, was not up update, as it did not include three people on respite. The plan referred to a fire 'Grab bag' (an emergency kit containing items such as emergency blankets, first aid kit etc). This was in the registered managers office, and not easily accessible. Medicines had been delivered to the service, and placed on top of the grab bag. The registered manager told us senior staff had access to their office when they were not on site, but the grab bag would not have been seen in the event of an emergency. This should be easily accessible in the event of a fire, and the registered manger relocated the bag immediately to the location of the fire panel, for ease of access.

Our last inspection found, individual risks to people had been assessed, but management plans to mitigate risks were not consistently followed by staff, or amended when their needs changed. At this inspection, we found identified risks such as falls, or risk of falls and injury, were not being well managed. For example, one person's pre-admission assessment states, 'uses walking frame, and will shuffle, and requires one member of staff to support to stand.' However, throughout the two days of our inspection we saw this person walking around the home, with no frame, or staff support. They were observed very unsteady on their feet holding onto door frames for support. There was the potential for this person to fall, and risk of injury, yet staff did not encourage or support them to use their frame as identified in their care records.

Incident reports and body maps were being completed, however the section 'action taken and recommendations' did not record sufficient in detail, what action had been taken, or what measures had been put in place to prevent reoccurrence. The falls log from January 2018 reflects there were 33 recorded falls,16 resulting in cuts, bruising to eyes, nose bleeds, bruising to face or head, but only four were admitted to hospital for treatment. The provider does not have a specific policy for dealing with head injuries. However, the accident procedure clearly stated that in the event of a head injury an ambulance must be called. Where people had obtained head or facial injuries and no ambulance had been called there was no record to show that regular monitoring of the person had been completed to check for signs of concussion.

This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Our previous inspection found that people's care records did not accurately reflect the level of support they needed at times when their behaviours could be challenging to others. At this inspection we found documentation had improved. Details about people's mental health and other conditions such as dementia that affected their wellbeing were documented, including verbal, physical aggression and how this was to be managed. Guidance, was provided to staff, and was unique to the individual, for example, '[Person] can be verbally and physically aggressive during personal care, staff guided to give the person a cup tea 15 minutes before personal care, approach person in a calm manner, speak calmly and ask permission before providing

personal care, if aggressive leave alone and return in a few minutes. One member of staff to assist with personal care, and may need to repeat sequence three to four times.' Staff had a good understanding of the support people needed, when angry, frustrated or anxious. One member of staff told us, "When people are anxious or agitated, sometimes just sitting and having a cup of tea helps them to calm down." Another member of staff, commented, "I sit and chat, try to put their mind at ease, if it doesn't work I get another member of staff to take over and see if they can try to diffuse the situation."

Our previous inspection identified people's medicines were not always managed consistently or safely. At this inspection we found the required improvements had been made. One person told us, "I don't take any medicines, I used to take blood pressure tablets, because I had a mini stroke, but not anymore. Staff spoke with my GP, and I don't need to take them now." Routine medicines were stored in locked trolleys and secured to the wall in medicines storage rooms when not in use. These rooms contained fridges used to store medicines. Log books for monitoring the daily temperature of the fridge and medicines room were being kept. Random sampling of people's routine medicines, against their records confirmed they were receiving their medicines as prescribed by their GP. Profiles were in place for each person describing their preferred method of how they wanted to take their medicines, for example, tablets to be placed in persons mouth, one at a time as they are at risk of choking and taken with a glass of water. Body maps were used to indicate the site where creams and ointments were to be applied. The records showed that staff alternated the site of pain patches and recorded appropriately the date when these were applied and removed. Where medicines were prescribed on an as needed basis, clear protocols were in place to guide staff when these should be administered.

Regular medicines audits were being undertaken. We reviewed the last three months June to August 2018. Overall, these reflected minor errors, which had been suitably managed. In August the audit identified a missing controlled medicine. The registered manager took appropriate action and notified the local authority safeguarding team, police and CQC. An internal investigation was completed, including a review of medicines by an external pharmacist to learn what went wrong. The registered manager implemented measures to prevent this happening again, including retraining of all staff who had access to or were responsible for administering medicines.

Our last inspection identified the fire service inspection in 2014 and had identified several areas requiring improvement, which had not been completed. At this inspection we saw the required improvements had been made. A business contingency plan was in place detailing who to contact in an emergency such as a lift breakdown, gas supply failure or if residents needed to be evacuated where they would be relocated to. Staff knew who to contact if such an emergency arose. Maintenance records showed fire alarms were regularly checked to ensure they were in good working order and the gas safety certificate was up to date. Water taps were fitted with thermostatic mixing valves and the temperature of the hot water was regularly checked to ensure that it was within a safe range for people to use. Records showed that the hoisting equipment was regularly serviced and personal electrical appliance (PAT) testing had been carried out to ensure that electrical equipment was in safe working order.

People told us they felt safe living at Chalkney House. Comments included, "I do feel safe, the staff look after me very well." One person when asked if they felt safe living at the service, told us, "Of course I do, I feel safe in my room." Another person told us, "I do feel safe here, but I get a bit worried sometimes, where some of the people who have dementia try to get into my room, I know it's not their fault, but I keep my door locked, so they can't get in." One person who was unable to express what safe meant, told us they had no concerns. They looked relaxed and comfortable.

Policies in relation to safeguarding and whistleblowing reflected local procedures and relevant contact

information. Additionally, posters were clearly displayed on notice boards throughout the service about safeguarding and how to whistle blow. These provided clear guidance to people, visitors and staff on how to report concerns within and outside the organisation. Staff told us they had received updated safeguarding training and were aware of different forms of abuse and their responsibility to report concerns, record safety incidents and near misses. They demonstrated a good awareness of procedures to follow and knew who to inform if they witnessed or had an allegation of abuse reported to them. The registered manager was aware of their responsibility to liaise with the local authority where safeguarding concerns had been raised and such incidents had been managed well.

Four out of the five people spoken with said there was always staff available if they wanted help. One person told us, "Staff are very good, they answer my call bell in a timely manner. If I need to ring my call alarm the staff are very quick to respond, even the night staff." However, one person told us, "Although there are enough staff, they are always very busy and don't have the time to properly sit and have a chat, I would like this to happen from time to time, not all the time, but now and then would be nice."

We observed there were sufficient care staff available to meet people's needs. Staff responded promptly to peoples call bells, reaction time was between one to two minutes. People told us this was normal. The registered manager told us current staffing levels were five staff across day time hours, including a senior, with three staff at night. There were two activities staff, who worked alternate days, across the week including weekends. The service currently had three staff vacancies, but the registered manager told us staff worked flexibly to cover shifts and staff absences. Agency staff were used when needed, but not recently. A national care forum dependency tool was used to calculate staffing levels and the registered manager advised this was reviewed weekly. If people's needs changed, staffing numbers were adjusted accordingly.

We reviewed the recruitment process in respect of the last three members of staff to be appointed and saw that relevant checks were in place to ensure that the staff members were safe to work with vulnerable adults.

Good

Is the service effective?

Our findings

Our previous inspection in February 2018 looked at how the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) were applied and managed in the service. We identified that people lacking capacity were not consistently supported when making decisions in line with current legislation. The MCA 2005 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 decisions made on their behalf must be in their best interests and as least restrictive as possible.

At this inspection we found the required improvements had been made. Where decisions were being made on people's behalf their family representatives and/or professionals were involved in making decisions that were in the best interests of the person. Where consent to treatment forms had been signed by family members; information had been obtained to ensure the family member was the persons Lasting Power of Attorney (LPA). A LPA is a person that has been appointed by the person to help them make decisions or to make decisions on their behalf, in relation to health and welfare and finances. People's care plans clearly documented how decisions about their care or support were made where they lacked capacity. For example, where a person had been assessed as needing support with eating, drinking, their personal care and taking their medicines appropriate MCA assessments had been completed. These agreed it was in the person's best interests to receive support from staff to take their medicines safely, ensure they were clean and had adequate food and fluids to stay healthy.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). The registered manager showed us a DoLS tracker which reflected applications had been made to the local authority for people subjected to restrictions to their freedom for their own safety.

Our previous inspection we identified people's nutrition and hydration needs were not always being properly managed. This had been due to poor record keeping. At this inspection we saw improvements had been made. The provider had introduced an electronic care recording system. A hand held mobile device (referred to as an iPod) was used by staff, which linked to the system. This provided a real-time record of care provided, for example the date and time, the amount of food and fluid provided, and consumed. The iPod also alerted staff when a person required a specific care need. For example, when a person was due to be repositioned to prevent pressure ulcers developing. If the task was not completed the registered manager received an alert to say this has not been done. One member of staff told us, "The new technology, has really improved how we record information. All the information, is logged, on the iPod including dates, times and the support we have provided. This shows how long the task took, and details in full when food and fluids have been provided and how much the person had consumed." Another member of staff commented, "The iPod is a much better system, rather than hand writing on forms, it takes up less time, which gives us more time to spend with people."

Staff told us, and records showed they had received a range of training, including topics to meet the specific needs of people who used the service, such as Parkinson's, dementia, nutrition and end of life care. Staff told us the training and support they received had provided them with knowledge and skills to meet people's needs. Staff told us most of the training they had completed had been done via computer based learning, known as eLearning. One member of staff told us they had completed up to 35 courses in the last three months via eLearning and we asked the registered manager how the staffs learning and knowledge was tested. They told us, eLearning was good in that it was self-directed learning, and staff can access mandatory and other courses of choice. They acknowledged there were pros and cons of eLearning, and was looking for face to face training in certain key areas, such as managing behaviours that can be challenging, specific to the people using the service. They told us they monitored the training on line, looking at the scoring and if staff have not scored highly, they were made to revisit the training. The head of care told us, they had completed a range of training, both face to face and via eLearning and commented, "The good thing about eLearning, is that you can start and stop, and go back, once you have completed and it reinforces what I have learnt on the original training."

When new staff joined the service, they told us they received an induction. Staff files showed they had completed a comprehensive induction consisting of both classroom training and computer based learning, including the Care Certificate. The Care Certificate was developed jointly by the Skills for Care, Health Education England and Skills for Health. It applies across health and social care and sets a minimum standard that should be covered as part of induction training of new care workers. We also saw that staff's competency was being assessed throughout the probationary period to ensure learning was understood and being applied. One member of staff told us, as part of their induction they had spent time shadowing more experienced staff for five days over a two-week period so that they could learn about people's needs and how best to support them.

People told us they enjoyed the food and said there was always two choices of main meals and a good choice of deserts. One person said, "Food is very nice, I have a choice, I don't' like curry, so when it's on the menu I have something totally different."

We observed lunch in both dining areas, in the old and newer part of the service. People were relaxed and there was a calm atmosphere. Some people were engaged in conversation, others were listening to background music. People were offered a choice of toad in the hole, or savoury mince, mashed potato and vegetables. The food looked appetising and people were shown plated options to enable them to make a choice. Where needed, people had been provided with adapted cutlery and plate guards to aid their independence. One person told us, "There is sufficient choice at mealtimes, and the quality of the food provided is 'Ace', in fact the food is too good there is too much." Another person commented, "I like the meals, there is a choice, I can choose what I want to eat each day, the food here is very, very nice." Other comments included, "The food is very nice, the meals are just right," and "The food is good, but I don't have much of an appetite." We observed staff giving people praise and encouragement to eat their meal, and offered more if they wanted seconds. They asked people if they were enjoying their meal, such as, "Did you enjoy that," people's responses were, "Good", "That was very nice" and "That was super." People, with poor appetite or experiencing weight loss were encouraged to eat little and often. We saw a range cakes, biscuits, crisps and sweets available throughout the day.

Staff were aware of people's dietary needs, for example one member of staff told us, "Some people, particularly those with Parkinson's, can't have solid food as they are at risk of choking, we have to make sure the consistency of the food is right, using thickening agents, as prescribed by the GP and Speech and language Therapist (SALT), to help making swallowing easier for them." Where people have specific dietary needs these were documented, in nutritional care plans such as diet controlled diabetic. Weight loss was

referred to dieticians, and under their advice people were provided with milk shakes and pro calorie shots to boost their calorie intake. Additionally, snack boxes had been placed in people's rooms, to encourage them to eat. The chef on duty, had good knowledge of people's needs, and was very clear about their specific dietary needs, including what food groups, such as butter, cream, full fat milk and milkshakes to fortify people's foods, where they needed additional calories due to weight loss.

People told us and records confirmed they had access to a range of healthcare services, such as the dietician, SALT, district nurse, continence nurse and the community mental health team. One person told us, "I have no concerns about my health, but I am waiting for a new chiropodist, as the current one has retired." A relative told us, "I can't fault the care, my [Person] has a condition that requires cream applied every day, and staff do it and they had physiotherapy when they needed it."

Chalkney House is one building which has been extended over the years. One person's relative told us, "The old building is lovely, if we didn't like it we wouldn't have moved [Person] here. Areas of the building referred to as the main house, cottages, extension, terrace and gables were all linked via corridors; however, there was minimal signage around the premises to guide people, particularly those with memory loss. Outside the room of each person there were photographs of the person's family, their loved ones, and their own pictures. These were useful in helping people remember where their rooms were. Since our last inspection there has been a programme of redecoration and some doors to bathrooms and toilets had been painted different colours, to help people distinguish between bathrooms and toilets. The courtyard garden had been nicely landscaped and provided a safe and secure environment for people.

Good

Is the service caring?

Our findings

People told us they were happy with the care and support they received and were positive about the staff. One person told us, "I am happy here, the staff are very nice, they are here to help me. You can have a chat and a laugh, laughter is important." Another person said, "I like being here, it's a nice place. The staff are very good, they are helpful."

One person told us, "The staff are very kind and caring, and my time here, so far has been very positive." The interactions between staff and the people using the service were friendly and staff showed concern for people's wellbeing. We overheard nice conversations between people and staff, for example, a person was heard talking with a member of staff about another care home, where they had a shared knowledge of the people that worked there. Another member of staff told us, "I like to sit and talk about the past with people, what their likes are, one person told me they liked to draw so I got them some paper and pencils, and they drew a picture of their dog. This was great because then we discussed their dog, its name, breed etc."

Staff had a good knowledge of people's personalities, their likes, dislikes and how they communicated. One member of staff commented, "I think it is important that we listen to people and establish what they want, to be a good carer is in your approach and the way you do it, I sing and dance with people, there's nothing worse than seeing people sitting doing nothing, it's about interaction." We saw staff made time to get to know people and things that mattered to them. For example, we heard a member of staff speaking with a person about fishing, and the air ambulance, which were of specific personal interest to them. Another member of staff was having a good conversation with a person about relationships, they asked the person, "Did you have a song with your husband that you used to love to, sing or dance too". The conversation moved on to talk about the staff members relatives wedding at the weekend. The person was really engaged and interested in the conversation.

Staff provided encouragement to people when they needed it and supported them to retain their independence wherever possible. This was confirmed in conversation with one person who told us, "I find the staff very nice, I have a good rapport with them, I don't find it too bad living here, the staff help me if I need them, but I like to be independent where I can."

People told us they were supported to make choices and decide how they spent their day. One person told us, "I do a lot of walking around, I like to look at the flowers and take notice of the garden." The PIR stated all decisions about people's care were made in their best interests starting with the care planning process and wherever possible people and their family were involved in the process. The registered manager told us families were invited to read and review people's support plans and this was confirmed in discussion with the relative spoken with. One member of staff told us they always asked people for their consent, before they provided care and support, for example, I greet them politely and ask would you mind if, or would you like help with? I respect their choice, if they refuse, I will leave them and try again later, or ask another member of staff to see if they respond better to them."

On admission to the service people's diverse needs, such as ethnicity, gender, religion and sexual

orientation was assessed and documented. Staff understood the importance of people being able to practice their chosen faith. One member of staff told us, "Religious services are held regularly here and people attended bible and prayer meetings. I regularly pray with the person I am a key worker too."

People were treated with dignity, respect and kindness. This was confirmed in discussion with the people we spoke with and staff. One person told us, "Staff treat me with dignity and respect, I am given a choice of what time I get up, go to bed, and what clothes I want to wear." Staff understood the need to always respect people's privacy and dignity. One member of staff told us, "Some people don't like having male carers, therefore we always make sure female residents have female staff to attend to their personal care needs, and vice versa for males." Another member of staff told us, "I always knock before entering a person's room, or the toilet, and always ask if they need help, I don't just do it. I understand people can be embarrassed when receiving personal care." Other staff comments included, "If I assist a person to the toilet I always make sure I shut the door, and if the person is confused I explain what I am doing," and "I always whisper in people's ears to see if they need the toilet and cover people's private parts when carrying out personal care. I treat people how I would wish to be treated."

Good

Is the service responsive?

Our findings

At our last inspection we were very concerned about how people were being supported at the end of their life. Despite providing end of life care there had been no links with the community palliative care team or hospice, or specific guidance with regards to end of life care. At this inspection we found significant improvements had been made. The registered manager told us they had established better links with the hospice, to provide better palliative care. They had also attended training on and implemented the Gold Standard Framework (GSF). This is a model that enables good practice to be available to all people nearing the end of their lives to ensure they receive the best care. The aim is to promote joined up care so that everyone involved in the person's care knows about their wishes and is best prepared to ensure that they are fulfilled. Staff told us they had also received training so that they had the skills to provide the highest possible standard of care for people when nearing, or at the end of their life. One member of staff told us, "Personal touches, that's what I do to make sure people feel loved, for example, just holding someone's hand, with music on in the background, and flowers in their room, it's not a nice thought dying alone."

An end of life policy had been implemented, in May 2018 which identified the actions staff needed to take to ensure people received the best provision of care at the end of their life. This included working closely with families and other health professionals. No one was receiving end of life care at the time of this inspection, therefore we reviewed the care plans for two people that had recently passed away. Their end of life wishes and preferences when nearing end of life had been respected. Both people, had a palliative care plan in place that covered all aspects of the care support and treatment they needed, for a comfortable and pain free death. We saw thank you cards on the notice board from relatives, which stated, "We can never thank you enough for the care you gave [Person] and the support you gave to us in the last few days, you always made us welcome, "and "Thank you for the kindness shown caring for my [Person] for the last seven years. [Person] felt safe and secure during their time at Chalkney House."

The Commission had also received positive feedback from relatives about their experience of their loved ones passing at the service. They commented, "We never felt our [Person] was neglected or at risk in any way. We never witnessed anything other than compassion to all the residents. We found the home to be friendly, homely and welcoming whatever time of day we called. About a week before our [Person] died they became unwell and wanted to stay in bed. As they didn't seem to improve, the doctor was called. I stayed with my [Person] to see what the doctor's opinion was, and they felt they was nearing the end of their life. We didn't want [Person] to go into hospital and opted for them to spend their final days where they were. The care given at the end of their life was very good. They were moved very quickly onto a special mattress to prevent bed sores, and moved into a larger room so there was room for us all to be with them at the same time. The district nurse called regularly. Staff, day and night were extremely good. We stayed with our [Person] as much as possible and saw how the home works in a way we hadn't previously appreciated. As a family we are unable to fault the care our [Person] and ourselves received at a very sad and worrying time." Another relative told us, "The end of life care was very good, all staff were caring and compassionate. My [Person] died peacefully and with dignity, amongst the people they knew and trusted. The staff were very caring and aware of the needs of us, the relatives and we could not have asked for better care. Throughout their stay, [Person] was well cared for, the staff were caring and friendly and we would recommend Chalkney

House to anyone looking for a care home."

Our last inspection identified that people's care plans were not always person centred and reflective of their needs. The registered manager told us a 'Resident of the week' initiative had been implemented and was helping to improve care plans and ensure the delivery of person centred care. They stated, "Every person at Chalkney House is special and we want them to feel that." The idea, behind the initiative was to invite families, to have a meal with their loved one, and engage with them about the person during the meal. This created an opportunity for an informal chat about the persons past, present and plans for future, to ensure the care they received was right. The registered manager stated, "This has improved relationships with relatives and they are now more open and transparent, with us." One relative told us, "My [Person] has had their turn at being 'Resident of the week'. We the family, were asked to come for a meal, we had fish and chips and a bottle of prosecco and an entertainer had come into sing to [Person]. We were provided with goodie bags with chocolate and scented candles, and the staff took photographs of the whole family, which they gave to us."

This initiative started in May 2018 and 14 people so far have been 'Resident of the week'. A book showing one person's 'Resident of the week' had been compiled, with photographs as a reminder. This person was on permanent bedrest; and had a passion for trains. A member of staff had brought in a trainset which they had set up in their room, for the person to enjoy. Another person had enjoyed a pamper day, having their hair done, a manicure, a meal with family, and the 'pat dog' came in specifically to spend time with them as well as an entertainer, who made additional time to talk with the person.

People told us staff responded to their needs. One person told us, "The maintenance person came into my room yesterday to sort out my pressure mattress, he was very nice." Records seen and discussions with staff confirmed they responded to people's needs, to ensure they received personalised care. For example, the head of care contacted the surgery for advice and as a result the GP was in the process of reviewing their medicines. One member of staff, told us, "People with dementia don't always understand their feelings, they need comfort and emotional support. For example, [Person] was crying this morning, they didn't know why, said it was just one of those days, we sat and had a chat, and I made them laugh, laughter is great therapy. They told me that made them feel better."

People told us they had access to a range of activities, within the home and via external sources, and chose if they wanted to take part. One person told us, "There are activities available, and I can take part if I want to. I enjoyed hangman this morning." Another person told us, "I am aware there are activities, but I don't wish to take part, I am 95 now, and can't do activities as my knees hurt." One relative told us, "They do have a lot of activities, my [Person] joins in as much as they can." Activities included, but were not limited to, reminiscence sessions, external entertainers, and singing along with music and exercises. One person told us, "There is a good level of entertainment available here, particularly outside entertainers, we have someone coming in today, I'm looking forward to that." Another person told us, "Singers come in sometimes in the afternoon, they are also coming tomorrow night, I like that." People told us they were supported to maintain important relationships. One person commented, "My family visit me frequently, they can stay as long as they like, there are no restrictions." Another person told us, "A person from my local church comes here every other Sunday for prayers and hymns."

At our last inspection in February 2018 we found although complaints were investigated in full and were looked at in a timely way, the outcome showed a culture of minimal acceptance when things had gone wrong and the responses were defensive in approach. At this inspection we saw one complaint had been made since February. This had been dealt with promptly by the registered manager and area manager, a safeguarding referral was made and a letter of apology provided to the complainant. The concerns raised in

the complaint had been used to improve the quality of care provided.

People knew how to complain and there was a complaints procedure, including feedback forms available. One person told us, "I would not hesitate to talk to senior staff or the manager if I was unhappy about something, or had a concern. I am positive any issue raised would be addressed."

The service had received several thank you cards from people's relatives. These included, thanking staff, for a person's resident of the week, commenting, "We had a lovely time on [Persons] resident of the week day. [Person] really enjoyed themselves. We are aware of the things you do for everyone there and my [Person] and that you go the extra mile. It is very reassuring to know that [Person] is being cared for well," and "Thank you for letting us spend a special day with our [Person] and our meal with them, it meant a lot to us." Other cards included, "There is some lovely staff at Chalkney House and it's nice to see how they interact with everyone and put a smile on people's faces," and "Thank you very much for all the support, care and kindness given to my [Person], since 2013, we really appreciated it."

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection we found the registered manager and area manager were completing audits of the service on a regular basis, however these had not been used effectively to identify where improvements were needed. We also found that an audit carried out by an independent consultant had identified issues with medicines management, but no action had been taken to make the required improvements. Following the last inspection, the provider sent us an action plan telling us how they were to address the issues we had found and by when.

At this inspection we discussed the action plan with the registered manager and what progress had been made. Whilst most of the actions were in progress, or actioned they had not updated the action plan to reflect this and demonstrate the continuous improvement. Additionally, the audits and observations used to monitor the quality of the service, were largely a tick box process. These had failed to identify the lack of cleanliness and poor quality of bedding we continued to find. The quality of bedding had been raised at our previous inspection. The registered manager had taken immediate action then to purchase new bedding, but there was no audit of bedding to check this was in good condition. Neither had the audits identified risks to people, for example, the missing Personal Emergency Evacuation Plan (PEEP), for a person on respite, or that two room numbers did not match the occupants, as listed on the fire grab sheet at the front of the PEEP folder. We also identified risks involved with free standing wardrobes, in people's rooms that could topple forward, if pulled, that the registered manager or area manager had not identified.

Incident / accident reports from January to September 2018 showed 16 people had obtained head or facial injuries, and that only four people had been taken to hospital. The providers accident procedure clearly states that in the event of a head injury an ambulance must be called. The area manager updated the incident / accident form during the inspection to prompt staff to follow the procedures moving forward, however the monthly audit of falls had not identified this concern.

This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The accident procedure also stated that all serious injuries needed to be reported to CQC and a Reporting Injuries, Diseases and Dangerous Occurrences (RIDDOR) notification completed. This type of notification needs to be completed when accidents in residential care home settings result in a person suffering an injury and being taken directly to a hospital for treatment. One accident report referred to a person fracturing two fingers. Although this had been reported as a RIDDOR incident, no notification had been sent to us, at CQC to inform us of the incident. Additionally, an incident where a person using the service had assaulted another person, had been raised as a safeguard alert, but CQC had not been notified. The providers policy clearly states that incidents of abuse, allegations of abuse and serious injuries must be reported in accordance with CQC regulations. Our records show that the registered manager normally submits the required notifications to CQC, but confirmed that on these two occasions, in error, they had omitted to do so.

The registered manager told us they attended regular provider meetings with managers from other services owned by the provider to share ideas and best practice. The minutes of the recent provider meeting held in April 2018, showed ideas for improving the services, implementation of the new General Data Protection Regulations (GDPR) and implementation of the electronic software had been discussed. Since our last inspection a deputy manager had been recruited and a new administrator. The registered manager told us this had been a huge benefit to them and the service. Where previously they had been managing all aspects of the service, the additional resources had freed up their time to focus more on their managerial duties. The registered manager told us they had been able to develop good working relationships with other agencies such as the GP, district nurses and local hospice.

The registered manger told us they worked on the floor alongside staff whenever possible so that they could monitor the day to day culture in the service. People, and staff spoke positively about the registered manager. One relative told us, "I came into see [Person] today, and to see the manager. They always make time to see me." Staff told us the registered manager was approachable, very hands on and supportive. They felt she demonstrated good leadership and set an example of how care should be provided. One member of staff commented, "Definitely, feel supported, I can approach them [Registered Manager] at any time." Another member of staff told us, "Chalkney House is a laid back, friendly and caring home. We have a good management team, and I wouldn't hesitate to go to the registered manager, area manager or provider, if I had a problem. I feel very supported."

The provider's statement of purpose contained the aims and objectives of the service. These were to ensure people's rights to independence, privacy, dignity, fulfilment and the right to make informed choices were respected. Staff were aware of these, however were less clear of the values set by the provider, which were compassion, able, respect, involve, nurture and genuine. Not all staff spoken with could name these values, but spoke positively about the culture in the service. One member of staff commented, "The culture here, is lovely, the staff and the manager are lovely and it's a great place to work. It may not be the Ritz, but everyone gets on really well, and that is what makes people happy." Another commented, "There is really good team work here, staff are friendly, we have a laugh with people and each other, there is never a dull moment."

Staff told us they received regular supervision and annual appraisal regarding their performance. Supervision is a formal meeting where staff can discuss their performance, training needs and any concerns they may have with a more senior member of staff. Staff told us they felt well supported by the registered manager and their colleagues. One member of staff commented, "The manager and senior staff are really good, if ever I need help there is always someone to help."

Staff told us and records showed that regular staff meetings were taking place. The minutes showed areas of concern were addressed, new policies and procedures discussed, ideas encouraged and good practice shared, for example what had worked well and where further improvements were needed. The minutes of the most recent meeting in September 2018, discussed the recent safeguarding concern and ongoing investigation around the missing controlled drug, and what lessons could be learned. Other issues discussed so that staff knew what was expected of them related to training, the new electronic based care planning systems and replacement champions for dignity, falls and nutrition. Champions are staff that have shown a specific interest in specific areas. They are essential in developing best practice, by sharing their leaning and acting as role models for other staff.

The registered manager told us they actively tried to engage with people using the service, their families, the public and staff. They were in the process of forming a 'resident / relative, staff and friend committee' of Chalkney House with the intention of giving a voice to all interested parties so that they could be fully

involved when making decisions about ways to improve the service.

One relative told us Chalkney House was recommended to them when they were looking for a suitable home for their family member. They commented, "I turned up adhoc, and felt this was the one. It is homely, I can't fault the staff, from the manager to the domestics, or the way they look after my [Person]. My [Person] has made a friend here, who is lovely and they enjoy their chats. There is a very friendly atmosphere. I would recommend this home to anyone." Another relative told us, "I sit and watch how staff interact with residents when I am here, they are fantastic. If I ever need to go into a home, then this is the one."

The most recent relative's questionnaires did not receive a good response, 37 questionnaires were sent, but only 7 responded. The responses were positive, all felt the service was safe, well maintained and well managed. Comments included, "Staff are very friendly, they have always helped when needed or asked," and "Staff I have met are a real credit to the team."

The activities coordinator held monthly meetings with people using the service to ask for their feedback. The minutes showed there were small groups of different people at each meeting to obtain a balanced view. Overall, there were positive responses, to a series of questions regarding staff, activities, food, the environment, concerns and management of the service. Comments included, "Management of the home brilliant, always there to help," and "I liked the seaside trip" and "I would like to go to the theatre." Where people had an issue, for example, one person referred to their room being small. They were offered a larger room, available in the older part of the service, but they refused.

One of the issues discussed at the providers management meeting in April 2018, was occupancy levels and the need to advertise in the community. An action was for the registered managers to ensure their web page, was up to date on an independent site available on the internet, for people to compare care homes and post reviews of their experience of services.

We reviewed this site and saw there were 13 reviews, all containing positive feedback posted about Chalkney House. These dated back to 15 April 2016 to the most recent review on 4 September 2018. Recent reviews, included, "The carers are friendly, happy and passionate about their work. No resident is left unattended, including the ones that are bed bound. Rooms are well equipped and a good size with en-suite bathrooms. Large enough for residents to have many personal items. Cleanliness is of a high standard. Residents clothes are changed every day. Food is prepared and of a high quality and understand locally sourced. Various events, some for fundraising, are organised throughout the year. They have a Resident of the Week event where the chosen resident is pampered for that week so they feel special," and "We feel the home has a lovely warm welcome feel and our [Person] is very happy there. Most of the staff are warm, attentive and compassionate. Staff are also supportive to family. Activities are brilliant.

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 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with the risks associated with the spread of infection because arrangements in place for the ensuring the premises were clean were not effective Regulation 12 (2) (h) How the regulation was not being met: People who use services were not protected against risks to their health and safety because risks were not consistently assessed or managed to protect them from harm or the risk of harm occurring. Regulation 12 (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to assess, monitor and improve the quality of the service were not used effectively to ensure the health, safety and welfare of people using the service. Regulation 17 (1) Regulation 17 (2) (a)