HC-One Limited

Chandlers Ford 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?	Good

Summary of findings

Overall summary

We undertook an unannounced inspection of this home on 25 April 2018. When we completed our previous comprehensive inspection of Chandlers Ford Care Home in April 2016 we found concerns relating to the management of people's pain and their wounds. At this time these concerns were reported under the key question of, "Is the service effective?" We reviewed and refined our assessment framework and published the new assessment framework in October 2017. Under the new framework these concerns are included under the key question of "Is the service responsive?" Therefore, for this inspection, we have inspected both of these key questions to make sure all areas are inspected to validate the ratings.

In April 2016 the home was rated Good overall with Requires Improvement in the Responsive domain as improvements were required in wound care and pain management in the home. At this inspection we saw these improvements had been made. In September 2017 we carried out a focussed inspection in response to concerns people had raised about the levels of staffing in the home. We were unable to substantiate these concerns at that time and the rating of the home remained Good. At this inspection we found the home remained Good in all domains.

Chandlers Ford Care Home 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 care home provides accommodation, nursing and personal care for up to 45 older people. Accommodation is arranged over two floors with stair and lift access to all areas. At the time of our inspection 25 people lived in the home.

A registered manager had been in place since 12 March 2018 at the time of our inspection. 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 legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Before the inspection, we had received concerns about the cleanliness and hygiene in the home from members of the public. At this inspection we were unable to substantiate these concerns. The home was clean and odourless and staff had a good understanding of infection control measures which were in place.

Whilst we received mixed feedback at our inspection about staffing levels in the home, there were sufficient staff deployed to meet people's needs and ensure their safety and welfare. Staff recruited to the home had been assessed as to their suitability to work with people.

People received care which was person centred and individual to their specific nursing needs. Staff had a good understanding of people's needs and clearly knew people well. The registered provider was taking

steps to improve the recording of people's social and personal histories in their care records.

There were effective systems in place to plan and implement end of life care for people to ensure this met their needs and preferences.

Risks associated with people's care, including the safe administration of medicines, had been identified and actions identified to mitigate these.

Where people could not consent to their care, staff sought appropriate guidance and followed legislation designed to protect people's rights and freedom. Staff knew how to keep people safe and understood how to report any concerns they may have about the care people received.

People received nutritious food in line with their needs, likes and preferences.

People were cared for in a kind and compassionate way and were encouraged to interact with each other and participate in a wide variety of stimulating activities and events.

There was a system in place to allow people to express any concerns or complaints they may have, and people and staff had the opportunity to express their views on the quality and effectiveness of the service provided at the home.

The home was well led. There were effective systems and processes in place to review standards of care delivered in the home. The registered manager promoted open and transparent communications and this was reflected in the home. People, their relatives and staff felt supported to express themselves and improve the service for the benefit of all.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remained Good.	**Good**
Is the service effective? The service had improved to Good.	**Good**
Is the service caring? The service remained Good.	**Good**
Is the service responsive? The service remained Good.	**Good**
Is the service well-led? The service remained Good.	**Good**

Chandlers Ford 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 took place on 25 April 2018 and was unannounced. The inspection was prompted by information provided to CQC from members of the public who had concerns about the quality of care people were receiving at the home.

Two inspectors and an expert by experience completed this inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home, including previous reports and notifications of incidents the registered provider has sent to us since the last inspection. A notification is information about important events which the service is required to send us by law. A Provider Information Return (PIR) had not been requested from the registered provider in time for it to be completed. A PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We spoke with twelve people who lived in the home and four relatives or visitors. We spoke with nine members of staff, including; the registered manager, the clinical lead, a registered nurse, a nursing assistant, three members of care staff, an activities coordinator, the head chef and the maintenance manager. During and after our inspection we received feedback from four health and social care professionals about the care people received in the home.

We looked at care plans and associated records for six people and reviewed the medicines administration system in the home. We looked at a range of records relating to the management of the service including records of complaints, accidents and incidents, quality assurance documents, five recruitment files and policies and procedures.

Good

Is the service safe?

Our findings

People felt they were safe in the home. One person told us, "Yes, [I feel] very safe. There is someone around all the time." Another said, "They [staff] are here to look after me and they do a great job, I am safe." Relatives and health and social care professionals felt people were safe in the home. One health care professional told us they felt the care in the home was good and staffing levels in the home had improved over the past six months to ensure people received safe care.

We had received concerns from members of the public about the levels of cleanliness and hygiene in the home. We were not able to substantiate these concerns at this inspection. We noted the home was clean and did not detect any malodours during our visit. We noted the provider put preventative measures in place where necessary, for example, ensuring the adequate provision of personal protective equipment (PPE) for staff, such as aprons and gloves.

Cleaning rotas were completed daily, were signed by relevant staff and were subject to regular audit. We undertook a 'walk round' of the home. We noted all areas, both communal and those used by staff, were in a good state of repair. There were hand hygiene stations around the home. All hand basins contained hot running water, soap and disposable towels. Bathrooms and toilets were clean and free of litter or debris. Staff had a good understanding of infection prevention and control issues; they received regular training and updates in this area.

We noted the provider undertook three monthly infection prevention and control audits. We looked at the most recent of these. They were relevant and up to date and issues identified, such as cracked tiles, were dealt with in a timely manner. The home had been subject to a recent influenza outbreak. The provider had correctly notified Public Health England and had worked with them to minimise the impact and prevent further spread. They had also conducted a post-outbreak infection prevention audit to identify areas for future learning.

Staff rotas showed there was a consistent number of care staff and registered nurses available to meet the needs of people though the day and night. This included the use of regular external agency staff, although the registered provider was actively recruiting staff to reduce the use of agency staff. The registered provider had a dependency tool in place. This is a tool which helps identify the needs of people and ensure there are sufficient staff available to meet these needs at all times. We saw this was used effectively to identify people's needs and allocated staffing levels remained consistent with these needs. Staff in most areas of the home worked in a calm and unhurried way, taking time to address people's needs

However, we received mixed feedback on staffing levels in the home from people, their relatives and staff. One person told us, "The staff are here when I need them, that is very important." Another said "I can't fault them, they are always around." However a third person told us, "This morning there was only one [carer]. I didn't get a wash until 11 [o'clock]. Normally it's about 7 [o'clock] which is good for me." A fourth person told us, "They don't have the staff. There is only one girl this morning."

A relative told us, "The only problem is when there are not enough staff. If someone goes off sick there needs to be a system in place. They [staff] have to wait ages for agency staff to arrive." However this relative went on to tell us, "[Manager] has made a big change to the home. The staffing level is better than it was." One member of staff told us, "It's okay if no-one goes off sick. If we get agency staff we know it's still alright but if they're new it's hard". A second member of staff was working alone on the lower floor of the home and told us there were not enough staff available in that area on this day and that this happened often, although there were staff in other areas of the home to assist with people's care needs. A third member of staff said, "We all pull together. Sometimes it can be busy but we cope."

We spoke with the registered manager about these concerns. On the morning of our inspection a member of staff had reported sick at the beginning of the early shift and we saw this was having an impact on the care staff could provide at that time. The registered manager acknowledged the absence of one member of care staff on the lower floor had had an impact on people but that they were addressing this and we saw that an additional member of staff came in to support staffing levels as soon as possible. We found the registered provider was taking all the necessary actions to ensure there were sufficient staff available to meet people's needs.

The registered provider had taken steps to address the challenges in recruitment of registered nurses in the home with the development of a nurse assistant programme. This offered existing and new care staff the opportunity to participate in additional training and become nurse assistants. The registered manager told us this would ensure staff with suitable skills and knowledge would be available to support the nurses within the home.

The registered provider had safe recruitment practices which were consistently applied. Staff files contained all the evidence required under Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full employment histories, right to work in the United Kingdom and professional references were on file along with evidence of photographic identity documents and proofs of address.

Disclosure and Barring checks had been obtained by the provider before people commenced working in the home. The Disclosure and Barring Service carry out checks on individuals who intend to work with children and adults who require care to help employers recruit staff safely. All nurses and midwives who practice in the UK must be registered with the Nursing and Midwifery Council (NMC). The service had checked registrations for nurses employed in the home which helped protect people from being looked after by unsuitable carers.

People were protected from abuse, neglect or harassment and the service had policies and procedures in place concerning safeguarding and whistleblowing. Staff members described types of abuse and told us some signs and symptoms that may indicate someone has been abused. Members of staff were familiar with the process they would use to report any concerns including those of abuse and were aware that they could approach outside agencies with concerns if they needed to. One member of staff told us, "I have done training within the last year. It did help because the guidance is always changing."

Risks associated with people's nursing and care needs had been assessed and informed plans of care to ensure their safety. These included risk assessments for; maintenance of skin integrity, moving and handling, falls, choking, nutrition and specific health conditions such as diabetes and weight loss. Plans of care were in place to mitigate these risks. For example, one person had developed a pressure wound prior to their recent admission to the home. There was guidance in the care plan to aid staff in the management of these wounds and review the risks which can contribute to such wounds including poor nutrition and mobility. For another person who was at high risk of falls, assessments had been completed and informed

their plans of care to mitigate this risk.

The risks associated with moving people in the event of an emergency in the home had been assessed. Personal evacuation plans were in place which provided information on how people should be supported to evacuate the home in the event of an emergency. A robust business continuity plan and home emergency evacuation plan were in place to ensure people were safe in the event of fire or other utilities breakdown such as a power failure.

The home was well maintained. Electrical, gas, and water checks were completed routinely in the home to ensure this equipment was safe to use. There were effective systems in place to identify maintenance issues in the home and how or when these were addressed. Equipment in use in the home such as a hoist, wheelchairs and lifts was well maintained.

People received their medicines in a safe and effective way from staff who had received appropriate training. There was a robust system of audit and review in place for the safe administration of medicines. For example, an audit of medicines in the home had been completed the day before our inspection and actions from this audit including the need to improve the clinical room in which medicines were stored had already been implemented. Medicines were stored and administered safely.

We looked at documentation related to falls, accidents and incidents in care plans and management records. They contained detailed information concerning the frequency, time and place of incidents, in addition to staff actions. They enabled the provider to identify the potential cause of these incidents and any patterns in these for people and across the home, with a view to reduction or prevention.

Good

Is the service effective?

Our findings

People were able to move around the home as they wished and staff supported them to remain independent and make choices in line with their needs and preferences. One person said, "I like to stay in my room. I can read, watch television and watch the squirrels. I go up [to the dining room] for lunch and to have a chat. I'm rather deaf so sitting in the lounge does not work for me." Another person did not like a very wide variety of foods and this made their food choices very limited. The cook told us how they worked with this person to ensure they were able to have whatever they wanted to eat and promote good nutrition for them. Health and social care professionals said staff knew people well and supported people to live as independently as possible whilst promoting their safety.

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

Where people lacked the mental capacity to make decisions the home was guided by the principles of the MCA. Staff had a good understanding of the processes required to ensure decisions were made in the best interests of people. Care records held information on how staff should support people to make decisions they were able to, such as selecting clothing, food choices and when to participate in activity. Decisions made in people's best interests were recorded and showed who had been involved in these.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards. These safeguards were well documented and staff could tell us when these were in place and the implications of these for the people they were supporting.

People enjoyed the food provided in the home. One person told us, "It's good [food], not like home food but its good. There is a choice of two things." Another said, "Beautiful, very good [the food]". Mealtimes were unhurried and people could take their meals in an area of the home of their choosing. The dining room provided a relaxed environment for mealtimes. Some people were supported with their meals in a lounge area or in their own rooms. Staff were attentive to people's needs and supported people when it was required without hurrying them or reducing their independence. We saw there were snack areas on each floor of the home where people who were independently mobile and visitors could help themselves to fruit, crisps, cakes and biscuits throughout the day; these included gluten free varieties. A coffee bar was being planned at the entrance to the home which would provide an area for people and their relatives to enjoy refreshments whilst socialising with others.

The staff we spoke with were knowledgeable about people's differing dietary requirements. They were aware of the importance of healthy eating, special diets and of maintaining a balanced diet. They were also aware of the balance to be struck between the need for this and people's rights to decide for themselves.

Care plans identified specific dietary needs, likes and preferences for people. A four week rolling menu of meals was provided and the cook was able to prepare other options for people if they did not want the daily selections. All food was freshly prepared and the kitchen was a clean and well maintained area.

The home environment provided a safe place for people to mobilise around independently. Corridors were wide and clear and allowed people to walk around the home independently and with walking aids without hindrance. Signage around the home was clear and bold allowing people to maintain their independence as they moved around the home. There were level access areas all around the home for people who required the use of wheelchairs and walking aids and lifts in place to provide easy access to the lower floor of the home. Outdoor areas were easily accessible and level to provide safe areas for people to enjoy.

A program of supervision sessions, induction and training was in place for staff and this was monitored by the registered manager and registered provider. This ensured people received care and support from staff with the appropriate training and skills to meet their needs. A staff matrix showed only 18 of 32 staff had received one to one supervision meetings; however, the registered manager told us group supervision meetings were held as part of staff meetings. The registered manager told us these helped staff to identify and address practice issues and provided an opportunity for feedback and learning to aid development. Records showed these were completed. Staff felt they were supported well with the training and supervision methods used. One staff member told us, 'I know I will be listened to in supervision. It's open and honest and I can say what I want." Another member of staff told us, "I was new to caring when I started here. There was training and then I shadowed staff for as long as I needed to."

Staff were encouraged to develop their skills through the use of external qualifications such as nationally accredited diplomas and other qualifications. Through the development of the nurse assistant role, the registered provider offered existing staff the opportunity to develop and enhance their skills through a designated training programme. This in turn supported registered nurses in the home in sharing their skills and providing support with medicines and other care practices. Registered nurses were supported to develop skills and ensure they were up to date with practice to meet the requirements of their registration with the Nursing and Midwifery Council (NMC).

Staff worked closely with health and social care professionals to ensure people received effective care in line with their needs. People were able to access a wide variety of health and social care professionals; this included access to GP's, specialist nurses, dieticians and speech and language therapists. Care records reflected these visits and actions were taken to follow advice given from these professionals.

Good

Is the service caring?

Our findings

People and their relatives told us staff were always kind and caring. People told us staff were, "Kind and caring," and, "Just lovely," as well as "Very friendly and kind." One person told us, "I am very lucky to live here, everyone is just so very kind and I could not ask for more." A relative told us they felt their loved one was well cared for and they would recommend the home to others. Staff felt they offered good care for people. A member of staff said, "Definitely [staff are caring]. I think it's a very caring place. I think it's outstanding."

People were supported in a kind and caring manner. There was a calm and inclusive atmosphere in the home. Staff took time to allow people to express themselves and participate in their care and activities as they preferred. For example, for one person who became distressed as they thought they were going to miss an important appointment, staff took time to explain to them that their appointment had been rearranged and so they did not need to worry about this. They then proceeded to support the person with an activity to help reduce their anxieties. There was a high level of interaction between people and staff and at times gentle banter when people laughed with staff and enjoyed their company. For example, one person told us how they enjoyed musical films and how the staff would join in when they were singing along to the music. They told us, "Staff make it fun." We heard people and staff enjoying a musical film and singing along together.

We saw people responded well to staff who knew them and understood how to meet their needs; for example, staff knew people's food preferences without referring to documentation and recognised how to support people with their mobility without reducing their independence. One person regularly tried to mobilise without their walking aid and we saw staff kindly and gently reminded this person of the need to take their walking aid wherever they went and encouraged them to remain independent. This person told us," Everybody is very nice. My memory is going and I can't remember what I am doing."

Staff consistently took care to ask permission before supporting or assisting people. For example, one person who required the use of a wheelchair to mobilise independently was struggling to move their wheelchair into a dining area. A member of staff asked the person if they would like assistance but the person declined and so staff did not interfere with the person's mobility. We saw this person was very appreciative of the staff member's patience in allowing them to remain independent.

Staff had a good understanding of people's personal history, likes and preferences including religious and cultural beliefs. Several people we spoke with chose to regularly attend or participate in religious services in the local community or the home. This was important to people and staff understood the need to respect this preference.

People felt staff were respectful of their privacy and dignity. Doors remained closed when people were being supported with personal care and when one person was being visited by a health care professional staff ensured they were offered privacy to attend to this person. Staff asked permission before supporting people to move or participate in any activity and were courteous and respectful at all times.

People and their relatives were able to express their views and be actively involved in making decisions about their care. Record showed care plans and risk assessments were discussed and agreed with people or their representatives. These were reviewed regularly by staff.

Good

Is the service responsive?

Our findings

People and their relatives said staff were responsive to their needs. A health care professional told us staff understood when they needed to involve them in the care of people and were responsive to meeting these needs.

Plans of care in place were securely stored and were individualised, mostly person centred and up to date. They held clear information on people's medical history, preferences, likes and dislikes and staff had a good understanding of these. Some information on people's social or personal histories was limited however this was an area the registered manager told us was being addressed at the time of our inspection and was identified in the Home Improvement Plan the registered provider had in place.

Staff communication was effective in meeting people's needs. Senior staff including the registered manager, the clinical lead, the deputy manager, head of maintenance and head chef held a meeting each day at a 'Flash' meeting. This meeting was a brief meeting to discuss and share concerns, accidents and incidents from the previous 24 hours and to talk about matters that may arise over the next 24 hours. Staff told us they received prompt feedback from these meetings that enabled them to stay current about peoples care needs and learn from incidents in order to reduce future risks. Daily handover information was printed and available on each floor of the home to provide staff with up to date information on people's needs

Care plans gave clear information for staff to meet the needs of people with specific health needs such as breathing difficulties and diabetes, recurrent falls, infection and weight loss. Information clearly demonstrated how people's independence may be reduced with these conditions, how they may present and what support staff should offer people. For people who lived with life limiting illness we saw staff responded to their changing needs in a timely and efficient way. For example, for one person whose health had deteriorated in the two weeks before our inspection, their care plans clearly demonstrated this deterioration in their condition and how they and their family had been involved in decisions about their treatment.

Chandlers Ford Care Home provided care for people at the end of their life. We saw people were encouraged to discuss their end of life preferences and this was well documented. Relatives were encouraged to visit and stay with people as they moved to the end of their life and we saw feedback from families of people who had passed away at the home thanking staff for the support and kindness they had been offered at this difficult time.

An activities coordinator told us about activities and meaningful occupations in the home. A weekly activities programme was displayed in the home and offered the opportunity for people to participate in a wide range of games, entertainment, trips and individual activities in the home. We saw people were able to participate in activities of their choice. For example during the morning of our inspection several people enjoyed a visit from a hairdresser whilst one person had their nails done. There was music playing in several areas of the home and one person read a paper in a garden area. A trip to a local venue took place using the

home's own minibus which was also available to take people to appointments. The activities coordinator told us of the strong support and good relationship they had with the local church and local colleges who regularly participated in activities with people.

People told us they enjoyed the activities in the home. One said, "Oh yes [there are lots of activities]. Some I join in with and some I don't. I like to watch the flower arranging." They went on to tell us they were going out on a trip on the day of our inspection. They said, "Last week we went to a café in Hamble. It was lovely." Another person told us, how they liked to come to the lounge area and read a paper or do the crossword where others were around. A third person told us they liked to stay in their room but that, "I go upstairs for the exercises which I enjoy." A fourth told us, "They [staff] are very good at providing entertainment. I pick and choose what I want to go to." The staff had recently celebrated National Care Home Day when they opened the home to about 40 visitors to celebrate the home together with people.

The registered manager displayed information about the home, how to make complaints and other documents such as menus and activity schedules in a format which people could easily access and view. This meant people had access to the information they needed in a way they could understand it and the home was complying with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

There had been two formal complaints in the home since our last inspection. These complaints had been responded to in line with the registered provider's policies and procedures. A relative told us of concerns they had raised with the registered manager about care their loved one had received. They told us this had been dealt with promptly. A copy of the complaints policy was clearly displayed in the home. The staff at the home had received many compliments from people, their families, friends and other visitors to the home, some of which were displayed in the home.

Good

Is the service well-led?

Our findings

People felt the service was well led and spoke highly of the registered manager and all the staff at the home. One person said, "I met the manager when I came in here, but I can't remember her name. I would talk to her; I know she is in her office." A relative told us, "All relatives are made to feel welcome with [registered manager] having an open door policy." A health care professional told us, "Since the new manager has been in place the home has improved." A social care professional told us they had confidence in the registered manager to maintain and further improve good standards of care in the home.

The registered provider required the registered manager and other members of staff to complete a robust program of audits to ensure the safety and welfare of people. Any actions identified through these audits were completed. These included audits on medicines, care records, infection control, environment, equipment checks and fire safety. The registered provider visited the home monthly or more regularly if needed to complete audits, reviews of care and provide support to staff at the home.

The staffing structure in place at the home provided a strong support network for staff and people who lived at Chandlers Ford Care Home. Staff had a good understanding of their role in the home and the management structure which was present to support them. The registered manager and a clinical lead provided senior leadership and registered nurses provided day to day clinical leadership in the home. A deputy manager was in the process of being employed to support the registered manager with management responsibilities. The registered manager told us they recognised the difficulties in recruitment of registered nurses in the home and wanted, with the support of the registered provider to explore different ways of working which would enable staff to meet the needs of people more effectively. One nurse assistant was employed in the home and there were further plans to employ a new member of staff to complete the training for this enhanced caring role. Staff told us they felt supported through supervision and regular team meetings and handovers which were used to encourage the sharing of information such as learning from incidents and new training and development opportunities.

The registered manager promoted an open and honest culture for working which was fair and supportive to all staff. With an open door policy, they were visible in the home and encouraged people and the staff to be proud of their home. A member of staff told us, "The manager is always on the floor and I can go to them whenever I need to." Another member of staff who was new to care told us, "I don't think I would have stayed without the support of the manager." A relative told us how the home had been led by a number of managers in the past four years but that, "…the home now has a very proactive manager [name] and [they] have made a significant difference to the standard of care for the residents."

People, their relatives and staff were encouraged to feedback on the quality of the service provided at the home through a variety of means of communication. Monthly meetings with people and their relatives were held with the registered manager. People were given opportunities to discuss any matters of concern they may have in the home and then actions were taken to address these. For example, one relative suggested the introduction of a keyworker system so that relatives understood which member of staff was responsible for communications with their loved one. This had been introduced.

Feedback was regularly sought from people and their relatives through the use of quality surveys. These showed people and their relatives were very happy with the care provided at the home.