Vijay Enterprises Limited

Le Chalet

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Le Chalet provides personal care and accommodation for up to 12 older people. It is one of two homes owned by Vijay Enterprises Limited. The service does not provide nursing care. People's nursing care needs are met by the local community nursing team. On the dates of inspection, the service had one vacancy. Some of the people at the service had physical and mental health needs.

This comprehensive inspection took place on 3, 22 and 23 February 2017. At our last inspection on 12 March 2015 we found a breach of regulation with regards to staffing levels. We asked the provider to take action to meet the legal requirement. We did not receive an action plan. We found this breach of regulation had not been met.

There was no registered manager in place. The last registered manager had left several months before and successfully deregistered with the Care Quality Commission (CQC) in November 2016. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how the service is run.

The service had a manager in place. They had applied to the CQC to become joint registered manager for both this service and another service owned by the same organisation in Cornwall, approximately 100 miles away. Staff felt supported by the new manager and felt the service had changed for the better. Following the inspection, the nominated individual confirmed the manager would not be continuing in their application to be registered by CQC at Le Chalet. They were actively recruiting for a new full-time manager.

Not all environmental risks to people had been identified and reduced. Hot water from taps was found to be in excess of the temperatures required under the Health and Safety Executive guidance. This put people at unnecessary risk of scalding. Following the inspection, the nominated individual confirmed this had been addressed and resolved.

Whilst there were some audit systems in place to monitor the running of the service, these did not include all of the areas required. The provider visited regularly but had not always checked on the quality of the systems and the running of the service. Following the inspection, the responsible individual confirmed changes in the management of the service.

The CQC had not received the formal notifications from the service. These are for events which affect the running of the service and are required to be sent by law.

There were not always adequate staff available on duty to meet people's individual needs and choices in a timely way. No dependency tool was used to assess people's needs and how many care staff were required to be on duty.

Staff did not always initially follow the correct infection control procedures to prevent the unnecessary spread of infection to people. However, these procedures were improved during the inspection.

The manager and staff had some understanding of the Mental Capacity Act 2005 and how it applied to their practice. However, the correct procedure for following the MCA had not always been followed. For those people who required it, applications had been made to the Deprivation of Liberty Safeguards team.

Staff were safely recruited, trained and supervised to do their jobs properly. They worked as a team, some of whom had worked there for several years. They knew how to recognise and report signs of abuse. They knew the correct procedures to report this.

People were very complimentary of the food. There had been recent changes in the kitchen and a new cook employed. They were in the process of developing new menu plans to reflect people's likes and dislikes. Food was nutritious and home-made as much as possible. Not everyone received the support they needed to eat their food and at the right times.

People felt safe at Le Chalet and were very complimentary of the staff. Lots of positive comments were given which included, "They (staff) are brilliant", "Staff are lovely", They (staff) are very helpful and kind … I can't think of a time they have not been kind … I couldn't wish for better" and "Staff look after me … it's very nice here."

People had an assessment undertaken before they went to live at Le Chalet and each person had a personalised care plan in place with all the information required. Individual risks were identified and reduced as much as possible. People had previously been able to take part in activities but since the activities co-ordinator had left these had been limited. A new co-ordinator was in the process of being employed.

People received their medicines safely and on time. Where necessary, staff sought advice and guidance from health and social care professionals and acted upon it.

People and their relatives knew how to raise any concerns and felt they would be listened to by the manager.

Visitors were welcomed into the home and felt involved in their relative's care. Relationships between staff and family members had been developed. Relatives were complimentary of the care staff and commented, "It's like home from home and my (family member) loves it … you couldn't wish for better care than here", "The (staff) do look after him … he gets everything he needs" and "My first impression of the home was people were sat outside laughing and joking and looked 'so happy'."

The service had an on going programme of continued maintenance and redecoration in place. This addressed all areas of the home and garden.

People's views were not always taken into account due to a lack of meetings, feedback and quality monitoring.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Health and Social Act (Registration) Regulation 2009.

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 always safe.

There was not always adequate staff employed to meet people's needs and choices in a timely way. No dependency tool was used to assess people's needs and how many care staff were required to be on duty.

People were at risk of excessive hot water temperatures from taps. However, this had been addressed. Infection control procedures were improved to ensure people were protected from unnecessary risks.

Medicines were safely managed by staff.

Staff knew how to recognise and report signs of abuse. They knew the correct procedures to report this.

People were protected by a safe recruitment process which ensured only suitable staff were employed.

Accidents and incidents were recorded and safely managed.

Is the service effective?

Requires Improvement

The service was not always effective.

The manager and staff had some understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. However, the correct procedures under the Act had not always been followed.

People enjoyed the food served and the improvement in the choice of meals. However, not everybody received the assistance they required to eat their food.

Staff received on-going training so they had the skills and knowledge to provide effective care for people. They received regular supervision and appraisals to monitor their work.

Advice and guidance was sought from healthcare professionals to meet people's health needs.

Is the service caring?

Good

The service was caring.

People and relatives were positive about the service and the way people were cared for.

Staff were caring and kind. Meaningful relationships had been built up.

Staff recognised the importance of family and friends. Visitors were welcomed into the home and felt part of their family member's care.

Is the service responsive?

Requires Improvement

The service was responsive.

People's needs were assessed and each person had a care plan in place. People received personalised care and support from staff which knew them well.

People were not always offered a range of activities to suit their individual hobbies and interests. However, a new activities co-ordinator had recently been employed.

There was a complaints policy in place but this required updating.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service did not have a registered manager in place. The manager also covered another service and shared their leadership time between both services.

The service had not notified the Care Quality Commission of all events which affected the running of the service as required by law.

Staff felt supported and listened to by the manager. They worked as a team.

There were some audit systems in place to monitor the quality of the service. However, these did not cover all the areas where improvement was required.

People's views and suggestions were not always taken into

account to improve and develop the running of the service.

Le Chalet

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.

The inspection took place on 2, 22 and 23 February 2017. The first visit was unannounced and the second and third visits announced. The inspection team consisted of one adult social care inspector.

Before the inspection we reviewed a range of information to ensure we addressed potential areas of concern and identified good practice. This included previous inspection reports and other information held by the Care Quality Commission (CQC), such as notifications. Providers are required to submit notifications to CQC by law about events and incidents that occur including unexpected deaths, any injuries to people receiving care, any person with a Deprivation of Liberty (DoLS) authorisation and any safeguarding matters.

We met and spoke with all of the people using the service and four relatives to hear their experiences and views. We spoke with the nominated individual, the manager, the deputy manager, five care staff and the cook. We also spoke with two health and social care professionals visiting the service.

We looked at the care records of three people, medicine records, three recently employed staff recruitment records, staff training records and a range of other quality monitoring information.

Following the inspection, the nominated individual sent us a variety of information and updates on changed they had already made to the service. They also included future changes they planned to make.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in March 2015 we had concerns that the current staffing levels were not able to meet people's needs safely at all times. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. As the legislation has changed since that date, suitability for staffing arrangements is now Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In March 2015 we identified staffing levels were not always maintained at safe levels. The previous registered manager had said this was because people's care needs had increased and become more complex, whilst staffing levels had not increased. There were people who needed assistance from two members of care staff at all times to support all transfers and assist with personal care. However, at times there were only two staff on duty. This meant there would be periods when both staff would be occupied with one person, whilst leaving other people unattended. There was a lack of care staff visible at lunchtime and teatime whilst people were eating. The service did not employ a cook and the two care staff also had to prepare meals.

At this latest inspection, we found the legal requirements had not been met.

On this inspection, there were two care staff (one male and one female) on duty throughout the day. This was also recorded on the staff roster as the agreed numbers. A cook was also on duty. When the manager was on duty they counted as a third member of staff but this was only three days a week. A large part of their time was taken up with management and administration duties. The manager and deputy manager were not on duty. The people who had required two care workers to support them at the last inspection still lived in the home. Another person now required two staff to support them.

We arrived at the home at 10.15 am. People had eaten their breakfast but one person joined the dining table late to eat their breakfast at 11 am. They had been assisted to get dressed by the male care worker. However, the person said they did not want to have personal care from a male and were quite upset. They were told they could have the female care worker but they would have to wait some time as they were busy elsewhere. The care worker confirmed this and said they explained they could certainly have the other care worker, but it would be some time before they were free and it was already 11 am. The person had agreed to assistance from them.

One person had finished their breakfast and was sat at the dining table doing a puzzle. Another person was also sat at the dining table. Staff explained they had remained there since eating their breakfast at 8 am. They were on their own rocking and humming opposite the other person. This person remained at the dining table until just before lunchtime when they were assisted to the bathroom. Raised voices could be heard in the communal area from the bathroom as the person was unhappy and upset as they did not want a male care worker to assist them. The male care worker was very patient and kind and asked the senior female care worker if they could help the person. However, the senior care worker was busy elsewhere as they were also in charge of the home. They did help as soon as they were free. This meant because there were only two care staff on duty, for those who preferred a female care worker they had to wait for their care

needs to be met.

The senior care worker gave out medicines. During this time there was only one care worker available. The senior care worker wore a tabard which asked people not to disturb them. On two occasions, this care worker was disturbed and had to stop giving out medicines; one occasion to speak with a relative who wanted to ask questions about their family member and another occasion when they had to give assistance to the other care worker. This meant the small lunchtime medicine round took almost an hour to complete. This meant people may be put at unnecessary risk of not getting their medicines on time or an error occurring due to the care worker being disturbed.

The two care staff also had to deal with telephone queries, speak with visitors, assist a community nurse and a physiotherapist and undertake cleaning duties as no housekeeper was on duty. This led to staff not being available in the communal areas, although call bells were answered promptly. Whilst there was no staff in the lounge area, there was also no call bell available for people to use should they require it, particularly in an emergency. The manager took immediate action and a call bell was made available in the communal area.

One person said they waited for a care worker to pass and then they shouted to them. We discussed the lack of staffing with the nominated individual and manager. We were told this was not a normal occurrence as the manager was also on duty and could work 'hand on'. However, the manager only worked three days a week at the home. No extra staff were on duty to cover their absence on the remaining four days when they were not at work at Le Chalet. When the deputy manager was on duty, they worked as one of the two staff on duty and were not supernumerary. As the cook worked six days a week, care staff also had to cook and serve food when the cook was not on duty. A part-time housekeeper was employed two days a week. This meant there were only two care staff on duty during the day and during the night with extra duties at times such as cleaning and cooking.

We observed two lunchtime meals during our visits. People ate their meals either in the dining room, their own rooms or the lounge areas. On the first day there was a lack of staff available to support and assist people at lunch. One person, who sat in the conservatory, required prompting and encouragement with their eating. However, staff had not seen this. When we asked a care worker if the person needed assistance, they started to help the person. However, by this time their food was cold and the person refused their main meal but ate their dessert. We discussed this with the manager who said this was not normal practice and immediate action would be taken to ensure enough staff were available to assist people to eat their food.

This was a continued breach of Regulation 18 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were very complimentary of the care staff and clearly enjoyed their company. Whilst all the care staff clearly enjoyed their work and were calm and helpful, they had very little time to actually spend with the people. Two said, "It could be easier … we are very busy" and "At least we have a cook now which helps a bit." The home used to have an activities person but they had left approximately six weeks ago so people's social interests were not being met. The manager confirmed they were actively looking to find a replacement and were in the process of interviewing suitable candidates.

On our second and third visits, whilst the home was still as busy, the manager and housekeeper were on duty which helped the care workers. This made the atmosphere more relaxed and calm.

Following the inspection, the nominated individual sent an updated staff roster which showed the staff on

duty each day, the times they worked and the changes in the staffing numbers. This included the cook who had chosen to work seven days a week, a manager five days a week and an activities co-ordinator three days a week. They confirmed people living at Le Chalet had reduced to nine.

During a tour of the building, we checked the hot water temperatures from sinks in communal bathrooms and bedrooms. These varied from being too hot in some, to not being hot enough in others. For example, in one communal bathroom and two people's bedrooms the temperature of the water from taps was between 52 and 56 degrees centigrade. This was excessive and too hot to put hands in. Health and Safety Executive guidance states water should be no hotter than 44 degrees centigrade. This put people at risk of unnecessary scalding. We discussed this with the responsible individual and manager. The manager said plans were in place to reduce the temperature of the water by the fitting of thermostatic mixing valves (TMV's). This was currently being completed in the provider's other service for the same reason. We discussed the immediate risk to people. The manager put signs up to warn people of the risk. They had made arrangements for a plumber to attend to give advice and make them safe. The fitting of the TMV's was planned as part of the maintenance programme to be completed in February 2017.

Following the inspection, the owner confirmed TMV's had been fitted to all taps in the home. They sent us an audit form to confirm water temperature was running at the correct temperature.

The home was clean and fresh throughout with no odours present. The laundry area was clean, with soiled and clean laundry kept separate. Staff had access to appropriate cleaning materials and personal protective equipment (PPE). They had received Infection control training. However, on our first visit care staff did not always wear their PPE appropriately. For example, two care staff did not wear gloves or aprons appropriately on several occasions. This was whilst they carried out personal care or served food. The infection control policy and procedure was out of date even though it had been reviewed in February 2017. This was discussed with the manager. They immediately arranged for a new policy to be written, booked infection control refresher training and purchased extra supplies of PPE for staff to use. This was to distinguish PPE from when staff gave personal care or were preparing or serving food. On our further visits, correct PPE was used appropriately.

People felt safe living at the home. One person said, "The girls look after me and they make me feel safe." Two relatives said their family members were safe. They said, "(My family member) feels safe here … we looked at a lot of different homes but this one felt right" and "(My family member) gets everything they need here … he is completely safe … staff are as 'good as gold'."

People were protected because individual risks had been identified. These included risk assessments relating to falls, skin integrity, safe moving and handing and nutrition. People who were at risk of skin damage due to immobility had equipment made available and in place. For example, staff had asked a community nurse to visit as they were concerned about a person's skin. The community nurse had suggested a pressure relieving mattress and the manager had organised for it to be fitted the following day. With the exception of the hot water, risks to the environment had been assessed. For example, staff had identified some of the tables people used in the lounge were not safe to put hot drinks on. The owner agreed to replace them during the inspection and to remove them from use.

Staff were aware of their responsibilities with regard to protecting people from possible abuse or harm. Staff had received training on safeguarding adults and whistleblowing and understood what abuse was. They knew how to recognise it and the correct action to take if they needed to report any concerns. They were confident action would be taken by the manager about any concerns raised. Up to date safeguarding and whistleblowing policies and procedures were in place. No recent safeguarding incidents had been raised

with the local safeguarding team.

Adequate recruitment procedures on prospective staff were in place. This ensured only fit and proper staff were employed. The staff files we looked at contained a satisfactory Disclosure and Barring Service (DBS) check and other pre-employment checks required. A DBS check provides information about any criminal convictions a person may have. The manager was in the process of updating the staff recruitment paperwork. They had a new application form which they intended to use and set questions to ask at interview. This ensured in the future the recruitment process would be more safe and robust.

People received their medicines they were prescribed. Medicines were managed, stored, given and recorded safely. Medicines were supplied by the local pharmacy in monthly blister packs which reduced any risk of error. Staff had received training on medicines and specimen signatures were held in the medicine administration record (MAR). This provided an audit of who had given medicines out. The home had some medicines which required extra monitoring. These were checked and matched the numbers there should be in stock. Temperatures of the trolley and fridge were regularly recorded and were within limits. A recent pharmacy audit had been carried out by the local pharmacist. All the issues highlighted had been actioned and rectified.

Incidents and accidents were reported by staff. The registered manager reviewed these and analysed the incidents. This ensured any patterns or trends were identified and managed accordingly.

There were arrangements in place to keep people safe in an emergency and staff understood these and knew where to access the information. Each person had a personal emergency evacuation plan (PEEP); this gave clear guidance as to how they would need to be supported to leave the building in the event of an emergency. For example, if they needed the assistance of one or two people and if they used any mobility aids.

In accordance with the relevant legislation, regular safety checks, servicing and maintenance of equipment were carried out. Systems ensured people were safe in the event of a fire. There was a fire risk assessment in place.

Requires Improvement

Is the service effective?

Our findings

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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager had some understanding of the MCA and the associated DoLS. However, there was a lack of information around the MCA assessments to ascertain whether people were able to make decisions for themselves in their care records.

Some 'best interest decisions' had been made for some people who were deemed unable to make decisions for themselves. For example, giving personal care. However, the correct procedure had not been followed; there was no mental capacity assessment, all relevant parties had not been consulted and any decisions had not been recorded. It was also not clear which relatives had the legal rights to make care and financial decisions on behalf of their family member (Power of Attorney POA). Whilst care plans referred to some family members having responsibility for finances, there was no records held in their file to confirm this. This meant staff were not always aware of people's relative's rights regarding their POA and the authorities they had. This had been identified on a recent independent quality assurance audit carried out by an external professional. The manager said they would immediately address this and take the necessary action. Both the manager and the responsible individual had booked to attend MCA, DoLS and safeguarding training at practitioner level. This meant their knowledge in these areas would increase and this could be used to support and guide care staff.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager had carried out some assessments on people to see if there were restrictions in place which required a DoLS application, for example the use of pressure mats (mats on the floor which alarm when a person walks on them) and bed rails. For those people who required it, DoLS applications had been made to the supervisory body.

Since the last inspection, the Care Quality Commission had previously received information of concern on two occasions that alleged meals at the service were unsatisfactory. These concerns had been discussed with the nominated individual, an investigation carried out and action taken. This had resulted in the two cooks in the kitchen leaving and a new cook appointed. This member of staff had been employed at Le Chalet as a care worker for several years. The cook had accepted a dual role at the service; cooking for 35

hours a week and caring for 12 hours a week. This meant the cook had an in-depth knowledge of people and their dietary needs by caring for them when not in the kitchen. They knew people well and their individual food likes and dislikes.

People were complimentary of the food. Comments included, "Food is good … good choices", "Food is brilliant … there is plenty of it … some of it was inedible before and I sent it back" and "Food is better now … it is changing …more choices." The cook worked from 9 am until 1 or 2 pm and ensured all food was home cooked as far as possible. During the inspection, the manager and cook confirmed they had increased the kitchen hours. This was so the cook could support and serve the majority of people their breakfasts instead of the care staff doing it. This would allow care staff to concentrate on their roles and deliver care only.

There were adequate supplies of fresh, tinned and frozen food available. The manager and the cook were introducing new foods into the service and improving the quality of food, for example home-made soups and buying higher quality food brands. There was a variety of home-made cakes available on all our visits which were served in the afternoon and teatime. Fresh fruit was available and cold drinks were available in both the lounge areas and people's bedrooms.

There were menu plans in place but the manager and cook were reviewing these to reflect people's personal likes and choices. People had a choice of two meals served at lunchtime and teatime and any special requests were served if possible. For example, one day a week (on the cook's day off) people had fish and chips from the local takeaway which they enjoyed. Two people required specialised diabetic diets. The cook was aware of both of these and ensured their food was prepared appropriately. They had researched diabetic desserts to allow these people more choice in their desserts than what had previously been offered.

One person had their breakfast at 11am when they had got up. This person remained sitting at the table until lunch was served at 12.30 pm when they then ate their lunch. When we asked a care worker if it was good practice to serve two main meals so close together they said, "It's OK; (person) likes to eat a lot." This was discussed with the manager who was in the process of changing the breakfast and lunch times to avoid this happening. They agreed this was not appropriate and to take the necessary action.

People received care and support from staff who had access to the training they needed. Care staff had received training which included: safe moving and handling; basic first aid; medication; fire, and the safeguarding of vulnerable adults. Training was delivered by a professional outside trainer on a regular basis. Staff also received training from the local care homes team on subjects such as diabetes, dementia and hydration.

A programme of training for the current year was in place. Records showed staff were up to date with their training and appeared knowledgeable about the courses they had undertaken. However, one relative expressed concern that staff "could have more understanding in diabetes and know more about the medication they were giving out". A health care professional said, "Staff ask questions but I think there is a lack of education here." We discussed this with the manager who had identified training had not been a priority previous to their taking up the post. Training had been difficult to organise at times with some poor attendance by care staff. In view of this, they had changed the times of the training to accommodate care worker's work-life balance; this had proved more successful. They also intended to check people's competencies when they had completed training courses and work alongside care staff to observe and monitor their hands-on care practice. The manager had identified diabetes training as a priority to be delivered in the near future.

New staff who had no qualifications in care undertook the Care Certificate (a nationally recognised induction training course considered best practice). One person had recently completed this with an outside trainer. The manager was reviewing the care certificate training with a view to supporting and encouraging people to do this in-house, with themselves as an assessor. There was a low turnover in care staff and most had worked at the service for several years. This meant staff knew how to meet people's needs fully.

Care staff received supervision and an annual appraisal. Records confirmed these had taken place and each member of staff had received recent supervision. The manager had previously identified these had not regularly taken place and had prioritised them. Staff felt supervisions were useful and one care worker said, "My supervision is useful … it finds my strengths and they are all discussed … it doesn't just find faults."

People had access to healthcare services for ongoing healthcare needs. Staff supported people to attend GP, nurse and hospital visits and escorted them. One relative said, "(Manager) takes (my relative) to the out patients department in the firm's car which is great." People's care records contained details of the person's GP and other health care professionals involved in their care. For example, staff had been working closely with the community nurses to support a person with diabetes. Where health concerns had been identified, a health care professional said appropriate advice was sought and followed.

Continued improvements to the interior and exterior of the home were planned. Since the last inspection, a new bay window had been fitted in the lounge. On our second visit, a maintenance person was painting walls in a corridor. A representative of a local furnishing company visited to measure up for new flooring in the some communal areas. Two relatives commented, "It's old fashioned here but (my relative) is happy here" and "It might not be the poshest place but the atmosphere is friendly." A health care professional said, "The home looks tired." This had been acknowledged by the provider and a programme of ongoing maintenance planned for the next twelve months. This included further redecoration, bathroom refurbishment, painting, furniture replacement and planting.

Large gardens were well maintained and accessible for people to use. Although the home was situated on a main road, there were areas at the rear of the garden where people could sit out in privacy and safety.

Good

Is the service caring?

Our findings

People received care and support from staff who had got to know them well. Conversations between people and staff demonstrated familiarity of people's preferences and interests. For example, we heard banter between a staff member and a person about a recent shopping trip and the clothes they liked. Another conversation related to a person's preference for a certain type of food they would like.

People spoke positively about the staff. Comments included, "They (staff) are brilliant", "Staff are lovely", They (staff) are very helpful and kind … I can't think of a time they have not been kind … I couldn't wish for better" and "Staff look after me … it's very nice here." Three relatives said, "(Family member) is happy here", "It's like home from home and my (family member) loves it … you couldn't wish for better care than here" and "The (staff) do look after him … he gets everything he needs." One relative said, "My first impression of the home was people were sat outside laughing and joking and looked 'so happy'."

Some staff had worked at the service for several years and told us, "I wouldn't work anywhere else … you really get to know people here", "I can't ever think of not working here" and "It's home from home here … people deserve respect and they get it." Staff interacted with people in a respectful, kind and caring way. They provided care in a calm and relaxed manner. There was a lot of laughter and gentle banter during our visits. One care worker said, "I love it here because we put the residents first … it's a small home with a homely feel."

Relatives said they always received a warm welcome from staff and were offered refreshments and snacks. Comments included, "I call in at different times and always welcomed" and "I always have cups of tea but I can stay for lunch and tea if I want." One visitor had a conversation with a member of staff about their relative's care. It was clear there was good communication between them and meaningful relationships had been built up. Relatives felt involved in their family member's care and comments included, "They always ring and let me know what's going on" and "They always keep me up to date". This showed staff recognised the significance of people's relationships.

Staff gave examples of how they maintained people's privacy and dignity and this was reflected in their interactions with people. One person said, "They (staff) look after my dignity and they are very kind." Another said, "The staff are always polite." A relative said, "All the staff are very polite and treat people with respect … I would move in tomorrow myself if I could." Staff were aware of non-verbal communications of two people. They were able to understand their needs and assist them in a timely way.

Personal care was provided discreetly and people were addressed in appropriately respectful ways. One person demonstrated how they used a certain sign to staff to let them know they needed to go to the bathroom. They said, "I go like this … staff come very quietly and help me to the toilet … they are very discreet." However, a health care professional voiced concern that people were not always treated with privacy and dignity on all occasions. They commented, "Staff don't always knock on doors and refer to people as room numbers … but they are not being unkind." During our visit, we saw an example of a person being referred to as the number of their bedroom. The care worker explained they did this to maintain

confidentiality as this was practice at the home. This was discussed with the manager who said they would take action.

People said routines were flexible. For example, they were able to decide what time they got up and when they went to bed. One person said, "I get up and go to bed whenever I want … you go to bed when you are ready. Sometimes they ask me and I say 'not yet' so they come back later." On our first visit, two people had enjoyed a 'lie in' at their request and did not get up until mid-morning. One person said, "We are looked after. I often ring my bell for assistance in the middle of the night and am always asked if I want a cup of tea."

No regular resident's or relative meetings had been held recently. The manager said they intended to start these as they would provide opportunities for people to share ideas and suggestions and to contribute to the way the service was run. People, relatives and professionals said they could speak with the owner or manager at any time should they have any requests or suggestions.

Requires Improvement

Is the service responsive?

Our findings

People said they had choices in their everyday lives. However, they were not always able to choose whether they wished to receive personal care from a female or a male care worker. At least two people required help and support from a female care worker. They were distressed when this did not happen (refer to 'safe' section). The manager and staff were aware who these people were, but this information had not been documented in the people's care records. One of these people did not always have the capacity to make the decision for themselves. People received care which was inconsistently planned and did not respect the choice of people's choice of gender of care worker. Assessments did not show their preferences in having a female care worker providing care. Nor was there any evidence of this being explored with the person in case this was not able to be provided.

There was a lack of stimulation at the service, although people did not raise any concerns to us about the lack of activities. Details of people's hobbies and interests were recorded in their care plans, but these were not always taken into account when planning activities. One person did puzzles and another read. Others watched TV or listened to music. However, the majority of people spent a large part of their day asleep. Their interactions mainly took place during personal care or at meal times. Outside activities were organised, such as church visits and entertainers. Activities were not planned on people's particular hobbies or interests, with the exception of one person. One person had individual contracted one to one social time of five hours a week. They usually left the home to go shopping or visit a local restaurant. They told us how much they enjoyed these trips.

The lack of suitable activities had been highlighted in a recent independent audit. Advice had been given as to suitable pieces of equipment for people's cognitive abilities. For example, rummage boxes, sensory items and comfort items for people with dementia. This had not yet been provided.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were two birds in the lounge area which people liked to watch. They also enjoyed spending time with the manager's small dog and spoke fondly of it.

The activities co-ordinator had recently left the service. The manager hoped to recruit a replacement shortly. They were in the process of speaking with a prospective employee.

Following the inspection, the nominated individual employed an activities co-ordinator for 15 hours a week. They intended to introduce activities for people in and outside of the home and had relevant experience of this type of work.

People received care and support which was responsive to their needs. Before people moved into the service, a visit was carried out to their current home by the manager. This enabled the manager to make a pre-assessment as to whether the person's needs could be met fully by staff. The assessment included brief

details about the person, their life and their current care needs.

When a person came to live at the home, they then had a full care plan put in place by the manager. Care plans were personalised and individualised. Each care plan contained information about the person's likes, dislikes and people important to them, for example an "All about me" plan. The care plans provided direction and advice for staff to follow to meet people's individual needs and preferences. For example, one care plan gave clear guidance as to how to assist someone to maintain their independence. Each care plan had a "care plan summary" which contained relevant information in a concise way.

Care plans included a life history of the person and links with their past lives. Some people's care files had a completed treatment escalation plan (TEP) in place. The manager was in the process of reviewing each person's needs; where required they involved the person's GP to put a TEP in place.

Care plans included a 'hospital passport'. This included a summary of important and useful information if a person suddenly had to be transferred to hospital. For example, their current medicines, how to safely move the person, the next of kin and how to communicate with the person. The information enabled the receiving care provider to have details of the person's needs immediately and without delay when providing care or treatment. This information was also recorded in the diary.

Daily records contained information about how people had spent their day. These included any changes in people's needs and this information was also shared at the shift handover. For example, if a person had not eaten full meals or if a person felt unwell.

People and relatives said they felt listened to and were happy to voice their concerns to the manager if necessary. They felt comfortable doing so and that their concerns would be resolved. One relative gave an example of an issue they had discussed with the senior care worker and how it had been resolved. The provider had a complaints policy and procedure in place but this did not contain all the up to date information required. For example, the contact details of the local authority, commissioning body or the local government ombudsman. The manager immediately spoke to the owner who agreed to update the policy immediately.

Staff felt able to raise concerns if necessary. The said the manager was approachable and they would be listened to. Two care workers said, "We are always listened to" and "The manager would deal with it (issue) straightaway."

Requires Improvement

Is the service well-led?

Our findings

Following the last inspection in March 2015 we requested the provider to submit an action plan on how they would address the breach of regulation identified and meet their legal requirements. This was to do ensuring the correct numbers of staff were on duty to meet people's needs fully. An action plan was not sent.

The provider is required by law to submit to the Care Quality Commission significant events such as injury, safeguarding concerns or other issues affecting the running of the service. The service had not submitted statutory notifications as required since February 2015. This demonstrated the provider did not act in accordance with their legal responsibilities.

This was a breach of Regulation 18 of the Health and Social Care Act (Registration) Regulations 2009.

Some quality assurance systems were in place to monitor the running of the service, for example care plans, risk assessments and medication audits. However, these did not cover all the areas necessary. Therefore any areas of risk, or those requiring improvement, were not identified and monitored. For example, not taking immediate action for the hot water temperatures, not identifying poor infection control practices and not monitoring staffing levels. All of these posed an unnecessary risk to vulnerable adults.

The nominated individual said they visited regularly and spent time at the service. However, they acknowledged they had not spent as much time at the service as they should. They planned to increase the visits and take more of an active management role in the running of the service. This included more stringent monitoring and improving the quality of care delivered. When they visited they carried out their own audits but these were going to be increased.

A yearly satisfaction survey of people using the service had been completed in 2016. Responses had been received but analysis of the results not yet completed. We discussed this with the manager who said they would review the surveys and record the actions taken.

The service had policies and procedures in place. However, some of these were out of date, had not been reviewed for some time and did not reflect current practices at the service. They contained out of date information and guidance for staff to follow, such as the infection control policy and the complaints policy. The nominated individual was in the process of updating these.

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

An outside professional had also completed an independent audit in November 2016 under the five domains. This had identified shortfalls at the service which were being addressed. Some areas had already been actioned, such as the completion of 'This is me' documentation, a change of cook, new menus and a maintenance log.

The service is required to have a registered manager. At the time of our inspection, there had been no registered manager in post since November 2016, although they had left the service several months before this date. There was a current manager in post who had day to day responsibility for the running of the service and worked part-time at the service three days a week. This manager was also responsible for managing another service two days a week 100 miles away from Le Chalet. Both of these services are registered with the same organisation. Therefore, the manager had reduced time available to manage the home. This was due to their increased responsibilities as they were dividing their management and leadership time between both services. The manager said it was difficult managing both services and that they were "completely different homes to manage." The manager had submitted an application to the Care Quality Commission (CQC) to become the registered manager of both services. This was in the process of being dealt with by the registrations team of CQC.

Following the inspection, the manager confirmed they had withdrawn their application to be the registered manager of Le Chalet due to personal reasons. The responsible individual confirmed they had recruited a prospective manager.

Care staff spoke positively about the manager and felt supported and listened to. They felt the service had improved since the new manager had been employed. Comments included, "It is a very happy team … much more in control … the manager listens and is very calm", "Everybody likes her … she is up front all the time", "If I have a query I just ask the manager … we can ask her anything" and "We've had a lot of upheaval recently but it's better now with the new manager." The manager was visible to people and their relatives in the home and easily accessible with an open door policy. People and relatives knew who she was and relationships had been developed.

The nominated individual had recently promoted a senior care worker to become a deputy manager for Le Chalet and lead the service in the manager's absence. However, neither the manager nor the deputy manager knew what the deputy's responsibilities were in the organisational structure of the service. The deputy manager worked predominantly as a member of the care team. The manager and the deputy manager both worked together on some days. This meant there were other days when neither of them were on duty. The manager provided a 24 hour, seven day a week cover for the service. Staff said they were always contactable by telephone and provided advice and guidance. The duty roster did not include the manager's hours and when they were actually on duty. This meant care staff could not be sure when the manager would be at Le Chalet or the other service.

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Records in place were kept securely and where it was necessary in the interests of confidentiality, access was limited.

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 18 Registration Regulations 2009 Notifications of other incidents The registered person must notify the Commission without delay of incidents which occur whilst services are being provided in the carrying on of a regulated activity, or as a consequence of the carrying on of a regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users must be appropriate, meet their needs and reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured the correct procedure of the Mental Capacity Act 2005 had been followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have an effective system in place to regularly assess and monitor the quality of the service provided and identify, assess and manage risks relating to health,

welfare and the safety of people who used the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured sufficient numbers of suitably qualified, competent and skilled and experienced staff were deployed to ensure people's needs, choices and preferences were met in a timely way.