Fieldhouse Care Ltd

The Chestnuts Care Home

Inspection report

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Normanton
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on the 24th November and 1st December 2015. The Inspection was unannounced.

The Chestnuts Care Home provides care with nursing for up to 41 people. It is situated in Normanton. The home is on two floors. Care is provided mostly for elderly people including those with dementia. At the time of our inspection there were two registered managers in place. One had left the Chestnuts several months before our inspection. There was a new manager in place who was in the process of registering.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.

Relatives of people who used the service told us they felt their relatives were safe at The Chestnuts; staff we spoke with recognised the signs of abuse and how to report this. Risk assessments had been undertaken, but these had not always been updated to reflect people's current needs. This poses a risk of the provision of inappropriate care, and risks not being identified or managed. Medication was administered appropriately and all staff who administered medication told us they received training and supervision before being deemed competent to administer. However, we were unable to access training we requested at the time of our visit.

The care staff had not received specific training around capacity and did not demonstrate a good knowledge in this area.

People who used the service and staff told us the food was good and we observed people being offered a choice at mealtimes in the form of a picture menu and verbally offering a choice. One of the cooks told us 'if people don't like the choices we will find something they do like'. The home had a monitoring sheet to note the food and drink intake of people at risk of malnutrition and dehydration. However this had not been inputted into accurately for two people whose care we reviewed, which meant the home had no evidence of what these people had eaten or had to drink. This demonstrated a failure to protect people from the risks of inadequate nutrition and dehydration.

During our inspection we found ten people in bed with their doors wide open meaning anyone who passed by could see in to the room. There was no documentation to ascertain if this was the people's choice.

Care plans and risk assessments were not person- centred and based around individual needs, this was evident in relation to equipment being used for moving people which could lead to people being put at risk of falls.

There was a lack of meaningful activities for people and in particular people those nursed in bed. This could lead to social isolation and associated complications such as depression.

Audits were not robust and did not have a good analysis; or follow- up plans in place. Policies and procedures for the home were out of date and several made reference to other homes. This meant that there were not effective systems in place for assessing, monitoring and mitigating risks relating to health, safety and welfare of people using

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.
If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service.

This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures"

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe
Staff we spoke with were able to recognise signs of abuse and what actions to take to report this but we saw that one person's rights were not being safeguarded in line with legislation.

Risks assessments were not updated to reflect changing needs and number of staff needed for specific activities in respect of moving and handling and fire evacuation

Medication was administered safely how ever we noted a medication error which was not dealt with in line with the Chestnuts policies and procedures.

The premises and equipment were not repaired in a timely manner

There were not sufficient staff to support peoples' needs, people had to wait unacceptable periods of time to have their call bells answered.

Is the service effective?

Inadequate

The Service was not effective

Most staff had limited understanding of the Mental Capacity Act 2005 and Depravation of Liberty Safeguards (DoLS) and some peoples rights had not been evidenced as protected under this legislation.

People were at risk of dehydration because they were not adequately supported to have sufficient fluid

There was a lack of staff support for people particularly at meal times.

Is the service caring?

Requires Improvement

The service was not caring

We observed several occasions where staff were not always respectful when talking to people living in the home.

We did observe some good interactions from some staff with people , however dignity was not always maintained as bedroom doors were left open when people were in bed.

Is the service responsive?

Inadequate

The service was not responsive

There was a lack of person centred care planning and we were unable to see how some peoples care was being assessed against their perceived needs

There was a lack of meaningful activity in the home to support peoples social needs particularly for the people nursed in bed

W e were unable to view the complaints process in practice as no complaints were in the complaints file had been received for us to review

Is the service well-led?

Inadequate

The Home service was not well led

Polices and procedures were not updated and some related to other homes

Staff did not have regular supervision

Audits were not robust

There was a lack of management oversight in the quality monitoring of the home.

The Chestnuts 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 2010

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR and we took this into account when we made the judgements in this report.

Before our visit we contacted the local authority Information received highlighted concerns by the infection control team in regards to lack of up to date policies and procedures this taken into account when planning the inspection. We were informed by the registered manager that these were up to date.

This inspection took place on 24/11/2015 and 01/12/2015 and was unannounced

The inspection team consisted of three inspectors. Before our inspection we reviewed all the information we held about the service. We spoke with five people using the service and three of their relatives. We spoke with nine members of staff including the manager, the registered manager, a nurse, a team leader, two care staff, the cook, and a member of kitchen staff and a visiting professional.

We used a number of different methods to help us understand the experiences of people who lived in the home. We used the Short Observational Framework for Inspection (SOFI) to observe care and support in the dining room during lunch time. The SOFI is used for observing care to help us understand the experience of people who could not talk with us; we reviewed six care plans and daily logs and also reviewed the registered provider's records about the service

Inadequate

Is the service safe?

Our findings

We spoke with people who lived in the home and their relatives. One person told us "Staff are understanding, and supportive I feel welcome this is my home". One relative told us "They [the persons relative] are safe here they are calm now."

We spoke with members of staff about their understanding of protecting vulnerable adults. They had a good understanding of safeguarding adults, and could identify types of abuse. They all knew what to do if they witnessed any incidents of abuse or neglect. Two members of staff told us they "had safeguarding training in their last jobs, not since being here." We looked at the staff training matrix and of the 44 members of staff listed 30 had yet to have safeguarding training. We were informed that this training was due to take place and shown a list of people due to attend. We also spoke with staff about whistleblowing, one member of staff told us "I haven't got any concerns but if I had I would tell the manager, they would listen to me, [the manager] is very approachable."

The manager told us they had not had any safeguarding training since being in post. They told us they had read the policies and procedures. The manager was able to tell us how they would respond if abuse or neglect was reported to them. This demonstrated a good understanding of the local safeguarding process. However we were concerned about the decisions made to care for people in bed following a fall, and in particular one person who lacked capacity to consent to treatment. There was no evidence we found that this person's rights had been protected under The Mental Capacity Act and as such the provider could not demonstrate that this person was not being unlawfully restricted. This demonstrates a breach of Regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at six care plans and identified risk assessments in each file. We found care plans and risk assessments for moving and handling, nutritional risk, Malnutrition Universal Screening Tool (MUST), falls, tissue viability (Waterlow) and medication. The risk assessments had not always been reviewed and did not reflect the current situation for people which could lead to staff following inaccurate risk reduction and moving and handling plans. We saw there was a range of equipment in place to help people remain independent. However, we found some concerns in relation to equipment being used. We noted a Rota Stand in the lounge - however, we could not find instructions for using the Rota Stand.The Rota Stand is a piece of equipment specifically designed and developed to allow the user a safe and secure assisted transfer from one seated position to another. We checked the care plan of the person it was used for and this stated "one person to assist." We discussed with the manager who stated it "required two people to assist." The manager was unable to locate any instructions for use. This meant the Rota Stand could have been operated in an unsafe manner. We saw in one person's moving and handling risk assessment that the Rota Stand was listed under equipment used for transferring in and out of bed chair wheelchair. The person's mobility was described as "independent normally with trolley." Further down the risk assessment it stated "wheelchair used for walking mobility." This information would not give staff a clear idea of how to help the person mobilise. The Rota Stand is a piece of equipment specifically designed and developed to allow the user a safe and secure assisted transfer from one seated position to another and should not be used to

enable people to get up and walk. Using the Rota Stand with this person would put them at risk of falls and injury

We looked at one person's care plan and risk assessment in relation to moving and handling. The risk assessment and moving and handling plan included a list of equipment such as raised toilet seat, wheelchair, bath hoist and shower chair and a Freeway shower chair. In the person's bedroom we noted the Freeway shower chair to be very low and without foot rests. We spoke with a member of staff who told us the person was "bed bound and didn't use any of the listed equipment' we asked how staff would know how to move people and were told 'information is in the care plan." This meant that this person could be moved incorrectly as staff did not have access to the current moving and handling plan or equipment used for this person, putting both the person and staff at risk of injury.
In another care plan we noted next to bathing / showering the staff requirement 'requires one person'. The care plan then stated "prefers to shower/bath/strip wash PM." The evaluation section stated "continues to require assistance of one carer for bathing." The moving and handling risk assessment did not have the bath hoist ticked in list of equipment. However; it stated "bathing-one carer/bath hoist." We asked staff how many staff were needed to use the bath hoist safely and staff reported that "two people were needed." The staff member demonstrated this for us. This meant that staff reading the care plan may use the bath hoist with just one staff member which was not as stated in the risk assessment and may have put the person and member of staff at risk of harm. The manager told us that since they had been in post they had "started to update the care plans and risk assessments and this was on going."This demonstrates a breach of Regulation 12 (2) (C) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the fire risk assessment, and a risk assessment document entitled accidents moving and handling environmental and fire. Both were dated 2012 and not specific to the home. A fire officer attended on the second day of our inspection and completed a risk assessment. These highlighted improvements for the home to make in regards to fire safety, including "annual fire alarm test to be changed to a monthly check. Lighting in the kitchen needed to be improved and the fire risk assessment needed tweaking as did not match the home." The fire officer reported he would accept a review of these.

Personal emergency evacuation plans (PEEP) for each person living at the home were evident in all the files we looked at. Each identified how to support the person to move in the event of an emergency. The files we saw had not always been updated to reflect the current situation. For example one plan stated "minimum of four carers to sledge to a safety point". A sledge is a foam device with straps used to evacuate people from buildings in an emergency. The home did not have a sledge in place; there was a fire evacuation chair. An evacuation chair would be used in a different manner to the sledge. This meant that there were not accurate instructions for staff to help evacuate the person from the building in an emergency. The fire officer told us "the chair was sufficient, however a second could be considered for the opposite end of the building." The fire officer recommended changes to the evacuation plans to match the building.

We noted the lift had been inspected in October 2015 by White Lift Services, it was deemed safe to use but had some defects which needed addressing. These included shaft lighting being poor and needing to be replaced, and car floor being damaged. The cooker had a warning notice issued; this was noted on the gas safety record dated 02/11/2015 - which stated "no interlock system fitted to the gas extractor appliance." The owner told us it was safe to use "as the staff have been trained not to use it until the extractor was on and windows open." The owner said they were aware of this and would fix it "when funds available." Boilers in the cellar were reported to be in poor condition in July 2015 and new installation was recommended. The owner told us this would be carried out "when funds available." All of these could lead to the service being unsafe for the people living there and staff operating the equipment. We noted on a tour of the building that

the first floor ceiling had water damage in several places; the owner informed us this was "cosmetic and not structural damage" however the owner was unable to provide evidence of this when asked for documentation. Subsequent to our inspection the owner has provided evidence that this has been rectified. This meant that the owner was not maintaining equipment and premises in a safe manner. This demonstrates a breach of Regulation 12 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the day of our visit we noticed a person in the lounge picking a tablet up from the floor. The person told us "this is not mine."
This was reported directly to the manager. During our inspection we did not see any action taken to identify the medication or who it belonged to, or any incident report being documented in relation to this. This meant that the homes procedure of dealing with medication errors was not followed. We looked at the falls analysis for the last quarter. There was unclear analysis in the form of handwritten notes for each month which identified trends for each month but no longer term. The notes were handwritten and not in order, making it difficult to see what analysis had taken place. The manager told us "there is no falls clinic in the area If someone falls, I look at the incident report, call out the GP to rule out any physical causes then consider falls mats." We looked at care plans for two people who had fallen. Following falls their care plans were updated stating they should be nursed in bed due to falling. There was no advice sought from GPs or other professionals and no documentation to identify why being nursed in bed was the correct plan for the person. We looked at one care plan following a fall. The care plan was updated to say "[person] is now nursed in bed following a fall and poor posture."
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During our inspection we noted bathrooms left unclean; the upstairs bathroom had a dirty toilet brush left in place. One upstairs bathroom had a puddle around the toilet. We noted a hoist with a dirty sling over it in a corridor. When pointed out to staff members all were rectified during the inspection.
The above examples demonstrate breaches of Regulation 12(1) (2)(b) (g)(I) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider was unable to demonstrate they were meeting the safety requirements of the people who lived at The Chestnuts

Inadequate

Is the service effective?

Our findings

All the people we spoke with told us the food was very good. One person told us "the meals make my day." The home had a five star food hygiene rating by the local environmental health agency. We saw meals and snacks were delivered to people who did not use the dining room. The food we saw was well presented. We saw kitchen staff asking people what they would like to eat. A picture menu was displayed on the dining room notice board; however it could not be viewed from all parts of the dining room and the pictures were very small. We were shown new menu cards which were being introduced for the tables. We noted that people nursed in bed had jugs of juice in their rooms; however they were out of reach which meant that a member of staff had to be called if any one nursed in bed needed a drink. This demonstrates that people were not being protected from the risk of dehydration. People were offered a choice of food and drinks at meal times in the dining room. However one person who was nursed in bed told us "It's not my choice it's what they give me."

During lunch time one member of staff was in the dining room with 14 people. One person required assistance to eat. This was done with minimal interaction from the staff member. The member of staff had to stop assisting on two occasions to help other people in the dining room.
During the lunch period we observed a person in their room shouting out for a drink, a staff member appeared and said "You're next I am coming to you in a minute." The person was observed shouting five minutes later - "Please someone get me something, anything will do I am so thirsty". Just as we were about to intervene, a member of staff brought the person's lunch and a drink to them. A member of staff told us "there is so much to do we can't get to people as quickly as we would like."

The people nursed in bed had food and fluid charts. We looked at three of these; one did not have a date on it and had not had a total fluid intake recorded for the previous day. Two others were filled in inaccurately stating that the person was eating lunch at 12pm. We observed the two people and no lunch was given to them until 1.15pm. This demonstrated that the nutrition and hydration needs were not being recorded accurately, which means they could not be monitored effectively.

These examples illustrated a failure to protect people from the risks of inadequate nutrition and dehydration. This is breach of Regulation 14 (4) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us no one in The Chestnuts required end of their life care at the time of our visit. We looked at the training matrix and saw that end of life care was marked as "not applicable" for 11 members of staff and only two members of staff had completed the training. The manager told is this is something they wanted to develop and had links with the local NHS trust however no training or support was in place at the time of our inspection.

The registered manager and the manager demonstrated a good understanding and knowledge of the

requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. 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.

The manager told us the previous manager had made some applications and they were aware of others which needed to be made.

The manager was awaiting training in MCA and DoLS which had been arranged at the time of our inspection. Staff had not received specific training about MCA and DoLS. The registered manager told us training for this was due and was able to show us a list of people due to attend the training sessions. The care staff we spoke with did not have an up to date knowledge around mental capacity or DoLS

We looked at two care plans in relation to MCA and DoLS. The first care plan had an assessment carried out with the outcome "requires a DoLs" there was no date next to this and no authorisation completed. In sections entitled "'cognition and mental state" and "moving and handling" "lacks capacity was documented" however no capacity assessments had been made. This meant that staff had identified that the person lacked capacity to make decisions about their care, however they had not made decision-specific capacity assessments in relation to certain aspects of care which could lead to decisions being made incorrectly for that person. Within the files a section entitled "MCA and DoLS" was included, however we found incomplete documentation in all of the files we looked at. This was the only section on mental capacity; no other assessment of capacity or best interest decisions had been made in any of the six files looked at.

In the second care plan we looked at there was a DoLs application which had been completed ten months previously, but no update was available. This meant that staff would not know if this DoLs application had been approved or not and would not be able to identify the correct process to follow to ensure decisions were made in the best interests of the person. This is breach of Regulation 11(!) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider cannot demonstrate that they are providing care with consent of the relevant person.

People were supported to keep appointments with hospitals, opticians and chiropodists. GPs and community nurses visited regularly to see people when needed. A professional who was visiting during our inspection told us "the staff are proactive in seeking advice and support." During our visit a person became unwell and we observed paramedics being called at the time which was appropriate as the person's health was declining.

We looked at three staff records and talked to staff about their training. We found staff were not having regular supervision One member of staff told us they had last had supervision "with the last manager" but could not recall a date. In one staff file we found no recorded evidence that supervision had taken place and in another record we found that the last supervision had been a group supervision eight months previously. The manager told us that supervision was "planned throughout the year with a minimum of four per year and more could be requested." The manger told us that the notes "were typed and put in to peoples' staff files." The policy for supervision had been reviewed in August 2015 and stated that staff should have a minimum of four supervision sessions each year. However we found there was no clear induction process in place. There was a care certificate booklet in place which the manager told us "was ready to roll out to new

staff." One file for a staff member had no evidence of training in place. The manager showed us a medication competency checklist which staff worked through before being responsible for medications. However the registered manager was unable to provide us with a completed form for one member of staff so we could not be sure that that particular member of staff was competent. These examples identified that the manager was not providing and recording training as necessary to carry out the role and demonstrates a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

People told us they thought the staff were very caring. One relative of a person living in the home told us "The carers and the nurses are brilliant, they really do a good job." We saw some staff spoke respectfully with people and they knew people well. We observed one staff member stop and chat to a person about the person's family. We observed that staff were very busy and on occasion rushed when helping people who were in need of support. One member of staff told us "It's important to remember people have been husbands, wives, working men and women; remember they are a person." They told us "I have to remind some staff members of this they don't always do it." One person told us "I am not always happy here, some staff do not even acknowledge me." One member of staff told us "Staff here are great they always give 110% that's why I stay here."

We observed people in bed throughout the day with no interaction or stimulation. We walked around the corridors at various times in the day and saw no sign of activities or interactions for the people nursed in bed. This could lead to social isolation. We spoke with one person nursed in bed who told us no one was interested in them, stating 'It's like I am not here.' One person who was nursed in bed told us "staff walk past, they don't always stop to talk to me they are not bothered". The person had had their breakfast at 6am that morning. They told us "it's not what I fancy it's what I get." 'No one's bothered; they come in and talk over me, I know about what happen on Coronation Street'. We observed a member of staff go in to the room, pick up a file and leave without speaking. This demonstrates a lack of respect from the staff member towards the person.

Throughout the inspection we observed some staff using child- like language with people and referring to people as "my little chicken. " During lunch we heard a member of staff say "open your peepers good girl, you're a good little eater." We did not see documentation in any of the care plans we looked at to evidence that people had been asked what they liked to be called other than their name. This meant that people were not being treated respect. We discussed this with the registered manager who said she knew which staff member this was and would speak to them.

Throughout the day we saw people's privacy and dignity was not well maintained, we noted eleven rooms with people sleeping or in bed wearing night clothes with doors wide open throughout our visit. There was no record of this in people's care plans to reflect if it was their choice. We discussed this with the manager who told us "It's difficult to observe people with doors closed." One person told us they liked to keep the door open "so I can see who is there." We also noted bathrooms without locks; this was pointed out to the owner during our inspection. This demonstrated a lack of consideration for peoples' right to privacy and dignity

During our inspection we observed staff reassuring a person who was upset during lunch by another person shouting. The member of staff went over and offered reassurance and stayed until the person was calm.

The manager told us volunteers had been selected to come in and sit with people and go through their "My Life', this is a section of the care plan that details a person's history, their interests and hobbies." In the care plans we looked at these sections and found that they had not been completed.

We noted in two care plans that the consent to care document had not been signed and found no evidence of people being involved in the planning of their care. Preferences and choices were not documented. The relatives of a person living in the home asked us why their relative was nursed in bed. We reviewed the care plan and could find no clear answer to this question. This meant that the person and their relative had not been involved in the decision to nurse the person in bed.

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The above examples show a breach of Regulation 10(1) (2)(a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider was unable to demonstrate they were treating the people who lived at The Chestnuts with dignity and respect. The people living in the home were not supported to be autonomous or independent.

Inadequate

Is the service responsive?

Our findings

A relative told us "the TV is always on but [my relative} can't hear it they are deaf. They are always in night clothes no matter what time of day I visit." One person told us "the care is as I like it but staff are always rushed."

We examined the care plans and daily records of six people. Personal details were recorded with a photograph of the person as well as their allergy status.

All Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms we viewed were original and stored in the front of the folders. The purpose of a DNACPR decision is to provide immediate guidance to those present (mostly healthcare professionals) on the best action to take (or not take) should the person suffer cardiac arrest or die suddenly. All the forms we viewed were original signed by a doctor and dated. This meant they were valid. All were stored in the front of the folders making them easily accessible. Each care plan included a personal agreement form which included a general consent for care and treatment. In two of the files we looked at this had not been signed. Each file contained a section entitled 'a snapshot about me and my life'. In two out of the six files we looked at these were not filled in. This meant there was no documented evidence that staff were informed about people's history, their preference, and likes or dislikes. The manager told us volunteers had recently been recruited to come in and go through these with people however they had not been in before our inspection. The manager told us the volunteers were from a local college and would be supervised by their manager and their tutors.

In one file we found the personal agreement to care planning not signed. The MCA form was filled in and assessed as needing a DOLS application in March 2015, however this was not filled in until August 2015. One risk assessment for bed rails had been updated monthly as "requires bed rails" with no further comments for three months. This meant that no review had taken place, highlighting a lack of care planning.

In one care plan there was a falls risk assessment, however it was not personalised and described 'monitoring of service user.' Following a fall there was no update to the risk assessment however documentation was made that 'due to posture becoming worse (person) is now bed bound.' This decision was made by staff in the home with no documentation of discussions taking place with occupational therapy, physiotherapy or GP. We discussed this with the manager who informed us that the 10 people nursed in bed all had poor seating posture and needed a specialist chair .On further discussion with the manager and the registered manager we were informed that they were looking to purchase one chair for all 10 people to sit out in. This demonstrates a lack of person- centred care and proper consideration of resource allocation to an identified need. If people require a specialist chair, the assessments should be made by an occupational therapist or physiotherapist to assess the requirements of that person and provide the correct equipment to support each individual.

We noted an activities list on the wall during our inspection. The manager told us a member of staff had taken on the role of activities coordinator and currently worked one day a week on activities. During our visit we saw a game of dominoes which six people took part in in the dining room. This was not the activity listed for the day. The game of dominos was led by a member of staff who had to ask the players how to play. We observed the people nursed in bed; of these 2 had a radio on, 1 had a television on; others remained in bed with no meaningful activity or occupation. This could lead to social isolation. It has been shown that social isolation can have a significant impact on physical health, and could be linked detrimentally to higher blood

pressure, worse sleep, immune stress responses and worse cognition over time in older people (1)
The above demonstrates a breach of Regulation (9) (1) (b) (c) (3) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.As people were not involved in planning or making decisions about their care.

We asked the manager about complaints and were told "there had been none since I have been here." The manager started her post in September 2015. We asked to see the complaints file and it was empty. This meant we were unable to assess how complaints were responded to. There was a complaints policy in place which had been reviewed in July 2015. Staff we spoke to told us they would refer complaints to the manager.

(1)Steptoe A, Shankar A, Demakakos P, Wardle J. Social isolation, loneliness, and all-cause mortality in older men and women. PNAS. Published online March 25 2013

Inadequate

Is the service well-led?

Our findings

A relative told us "the new manager is making improvements things are changing". At the time of our inspection there were two previous managers still registered with the Care Quality Commission. The current manager was in the process of registration. The manager told us one of the registered managers had left the organisation and the other was in place until their registration was approved. The manager told us they had on going support from this registered manager. The registered manager told us they were present at The Chestnuts at least twice a week and were available by telephone for advice when not in the building. The manager had been in post for three months at the time of our inspection and told us they did not have care home management experience or care home manager qualifications. They informed us that they were a registered nurse. The manager told us they were in the process of building up knowledge of the daily practice and an overview of the service. They went on to say that on some days they worked clinically due to short staffing. They described how this gave an insight into how the home was being run and which areas required improvements. However this meant that there was a lack of oversight and leadership at the home during these periods.

The manager described having an open door policy for staff, visitors, and people who lived at The Chestnuts. Staff we spoke with told us the culture in the home was open and transparent and they felt they could go to the manager and registered manager with any concerns. Staff we spoke with told us they worked well as a team and supported each other. The home held regular staff meetings and management meetings and we were able to see minutes of these meetings; however the minutes did not provide evidence of learning or actions taken following the meetings. The manager was visible in the home as she often worked clinically. The registered manager told us that they were in the home twice a week however - during our initial tour of the building they took us to the training room on the second floor and did not appear to be aware that it had been used as a store room for some time.

We saw the home had policies and procedures in place, however these were not always related to the home and not updated. The registered manager told us some of the policies were from the previous owner who had left the home in 2013. We reviewed policies in relation to 'Consent to Care, Dementia, DoLS , Equality and Diversity, Resuscitation, and Fire Safety Procedures'.
The 'Consent to Care' policy had not been signed, dated, or reviewed; the Dementia policy related to a different home. The DoLS Policy was recorded as created in 2011, but included changes to the policy which came in to effect in 2014. The Equality and diversity policy related to a different home. The policy on resuscitation equipment described a resuscitation trolley and was last reviewed in 2012. We discussed this with the manager who told us "The home does not have a resuscitation trolley." Fire safety procedures described different coloured fire extinguishers. Colour coded fire extinguishers have not been in use since 1997, yet this policy had been reviewed in August 2015.

Audits were carried out by the manager; these were not robust and lacked actions taken. There was a monthly falls audit with hand- written notes over all areas, making it difficult to read. There was no overview of how many falls each person had had or what had caused the falls. We looked at the moving and handling audit and saw that it had been completed in October 2015 but had no specific date. It was not clear what

actions had been taken when an issue was identified. Accident and incident records had no space for action taken, this meant that this information was hand written on the back of the form and was often not relevant. One form had a hand- written analysis on the back dated ten days after a fall and recommended that the person be monitored hourly and be transferred with assistance of two members of staff. Another identified a person who had repeated self injurious behaviour; however after the incident there was no analysis documented.

The care plans and risk assessments we looked at did not always have up to date information in them, particularly in regard to moving and handling - and had not been reviewed. In one care plan we saw documentation in the daily notes stating "no new issues raised." This demonstrates a lack of management oversight of the quality of service being delivered, as these shortfalls were not picked up through quality monitoring of the service.

These examples above show that there were not effective systems in place for assessing, monitoring and mitigating risks relating to health, safety and welfare of people using the service. This was a breach of regulation 17 (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Lack of person centred care planning Manager planning to purchase one chair for ten people Care plans and Risk assessments not updated to current needs of people

The enforcement action we took:

warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Building and equipment not repaired not in a timely manner. Rota Stand had no instructions for staff use Risk assessments not updated meaning equipment could be used in unsafe manner

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Lack of management oversight Audits not robust Lack of staff supervison

The enforcement action we took:

warning notice