St. Cloud Care Limited

Chestnut View Care Home

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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This was an unannounced inspection which took place on 11 January 2016.

Chestnut View Care Home provides nursing care and accommodation for a maximum of 60 older people who may be living with dementia and or a physical disability. They also provide respite care. (Respite care is a service giving carers a break by providing short term care for a person with care needs). Accommodation is provided over three floors. The top floor is primarily for people with nursing needs, the first floor is for people living with dementia and nursing needs and the ground floor is primarily for people living with dementia. At the time of this inspection there were 51 people living at the home.

During our inspection the manager was present. The manager had been in post since December 2015 and was in the process of submitting an application to us to be the registered manager. 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.

Chestnut View Care Home was last inspected on 31 March 2015 when it was given an overall rating of 'Requires Improvement'. Four breaches of Regulations 11,12, 17 and 18 were identified and requirement notices were issued. These related to medicines, consent to care, staff training and support and quality assurance systems. At this inspection we found that the requirement notices were met.

Although the manager had only been in post for six weeks prior to our inspection she was aware of the areas of the service that needed to improve and had started to take action to address these. Everyone that we spoke with said that the manager was a good role model and that she was implementing and driving positive changes at the home. There had been an increase in staff meetings and people were now being encouraged to be actively involved in making decisions about the service provided. Residents and relatives meetings had also been reinstated. Quality assurance systems had been reviewed and more robust monitoring of actions needed to be taken introduced in the form of a continuous improvement plan.

People said that they felt safe and we observed that they appeared happy and at ease in the presence of staff. In the main, potential risks to people were assessed and information was available for staff which helped keep people safe. We did note that for people who lived with dementia physical and emotional risks were not always linked. We have made a recommendation about this in the main body of our report.

Robust recruitment checks were completed to ensure permanent staff were safe to support people. However, this was not the case for agency staff. We raised this with the manager and the Nominated Individual who informed us that the staff from the recruitment agency would cease to be used with immediate effect. People told us that there were, on the whole, enough staff on duty to support them at the times they wanted or needed and we observed this to be the case for the majority of our inspection. We did

note that people who lived with dementia did not always receive assistance at mealtimes. We have made a recommendation about this in the main body of our report.

People said that they were happy with the medical care and attention they received and we found that people's health and care needs were managed effectively. Medicines were managed safely at Chestnut View Care Home. People's needs were assessed and care and treatment was planned and delivered to reflect their individual care plan. The manager showed us life story books she and the activities coordinator had been working on to reflect people's journey so far who lived with dementia and their likes and choices. This was a work in progress and had not been shared with the wider team at the time of our inspection. We have made a recommendation about this in the main body of our report.

People said that they consented to the care they received. Mental capacity assessments were completed for people and their capacity to make decisions had been assumed by staff unless there was a professional assessment to show otherwise. We saw that least restrictive practices were being followed. However, these were not always recorded. We have made a recommendation about this in the main body of our report.

People said that the food at the home was good and that their dietary needs were met. There were separate dining rooms located on each of the floors of the home which helped promote an intimate dining experience for people. However, we found that there were inconsistencies around the choices and support for people who lived with dementia. We have made a recommendation about this in the main body of our report.

Equipment was available in sufficient quantities and used where needed to ensure that people were moved safely and staff were able to describe safe moving and handling techniques. Effort had been made to ensure the design and decoration of the home was suitable for people who lived with dementia. We were shown bathrooms that the manager had arranged to be decorated in a style that was less clinical than they previously were. The manager explained that access to the garden was also going to be improved once a planning application had been approved by the local council.

Information of what to do in the event of needing to make a complaint was displayed in the home. During our visit we observed staff assessing if people were happy as part of everyday routines that were taking place.

Staff were skilled and experienced to care and support people to have a good quality of life. New staff completed an induction programme and were provided with training and supervision after this.

People said that they were treated with kindness and respect. We observed interactions by staff to people that were warm, positive, respectful and friendly whilst remaining professional. We observed that staff routinely checked that people were happy with the support being offered. Staff understood the importance of respecting people's privacy and dignity and of promoting independence.

People said that they were happy with the choice of activities on offer and that they were supported to maintain links with people who were important to them.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks were assessed and managed well, with care plans and risk assessments providing information and guidance to staff. Further work to link physical and emotional risks for people living with dementia will enhance this further.

There were enough staff on duty to support people and to meet their needs. However, how staff were deployed impacted on the support some people who lived with dementia received.

Staff employed by the registered provider underwent complete recruitment checks to make sure that they were suitable before they started work. However, verification processes were not always followed when agency staff were used.

People told us they felt safe. Staff understood the importance of protecting people from harm and abuse.

Medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were sufficiently skilled and experienced to care and support people to have a good quality of life. However, a lack of detailed information about the emotional and psychological needs of people living with dementia resulted in some staff who were not confident when caring for people who lived with dementia.

People consented to the care they received. Chestnut View Care Home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). The home followed the requirements of the Mental Capacity Act 2005.

People were supported to eat balanced diets that promoted good health. However, the dining experiences for people who lived with dementia did not always promote choice.

People told us that they were happy with the medical care and attention they received and we found that people's health and care needs were managed effectively.

Effort had been made to ensure the design and decoration of the home was suitable for people who lived with dementia.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion by dedicated and committed staff.

People were supported to express their views and to be involved in making decisions about their care and support.

People were treated with dignity and respect. Staff were able to explain how they promoted people's dignity and privacy.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care and treatment was provided in response to their individual needs and preferences.

An activity programme was in place and people expressed satisfaction with the range of activities available.

People felt able to raise concerns and were aware of the complaints procedure. Systems were in place that supported people to raise concerns.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The manager was aware of the need to promote a positive culture which was open and inclusive and had started to take steps to do this.

Quality monitoring systems had been improved and were being used to identify and take action to reduce risks to people and to monitor the quality of service they received. Plans were in place to address areas of service identified as needing improvement.

People spoke highly of the manager and said that the home was well-led. Staff felt well supported and were clear about their roles

and responsibilities.

Chestnut View Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 11 January 2016 and was unannounced. The inspection team consisted of three inspectors and a specialist dementia nurse advisor.

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. We reviewed the completed PIR and we checked information that we held about the home and the service provider. This included information from other agencies and statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection.

During the inspection we spoke with 10 people who lived at the home and three relatives. We also spoke with five care staff, a nurse, a quality assurance consultant, the manager and the nominated individual. Prior to the inspection we made contact with six external health and social care professionals, one of whom agreed for their views to be included in this report.

Some people at the home were living with dementia and we were unable to hold detailed conversations with them. Therefore, we spent time observing the care and support that people received in the lounges and communal areas of the home during the morning, at lunchtime and during the afternoon. We also observed part of the medicines round that was being completed.

We reviewed a range of records about people's care and how the home was managed. These included 11 people's care and medicine records, staff training, support and employment records, quality assurance audits, minutes of meetings with people and staff, menus, policies and procedures and accident and incident reports.

Chestnut View Care Home was last inspected on 31 March 2015 when it was given an overall rating of 'Requires Improvement'. Four breaches of Regulations 11, 12, 17 and 18 were identified and requirement notices were issued.

Requires Improvement

Is the service safe?

Our findings

People said that they felt safe and we observed that they appeared happy and at ease in the presence of staff. One person said, "I feel safe here because they are staff around and it means my family don't have to worry about me." Another person said, "When I walk there is always someone with me. I won't walk unattended as I wouldn't feel safe." An external health and social care professional wrote and informed us, 'My client is safe. They have managed to acquire all the equipment they require to keep him safe and comfortable'.

In the main, potential risks to people were assessed and information was available for staff which helped keep people safe. This included assessments in relation to falls, pressure areas, malnutrition and moving and handling. We did note that one person symptom's that related to a medical condition had not been considered. They had a falls risk assessment which identified potential risks associated with mobility. However, this did not consider the symptom's they may experience linked to the medical condition. The same person has risk assessments for eating and drinking, dementia and behaviours and care plans that detailed how risks were to be managed. We noted that it was reported that the person had hallucinations. There was no detail about what form the hallucinations took or what support should be given to the person to minimise their distress.

It is recommended that the registered provider reviews its risk management systems in order that they link physical and emotional risks for people living with dementia.

Robust recruitment checks were completed to ensure permanent staff were safe to support people. However, this was not the case for agency staff. Permanent staff files confirmed that checks had been undertaken with regard to criminal records, obtaining references and proof of ID. They also included checks on eligibility to work in the United Kingdom (UK) and confirmation that nurses were registered to practice with the National Midwifery Council. The home used staff from a recruitment agency to cover shifts when needed. Prior to our inspection we received information of concern about the recruitment agency's procedures to ensure people were legally entitled to live and work in the UK. We wrote to the provider who confirmed they used staff supplied by the recruitment agency. But they had systems in place that assured them staff from the agency were safe to work at Chestnut View Care Home. At this inspection we found that although the home obtained a staff profile from the recruitment agency and copies of passports they did not verify the information contained in the profiles. We raised this with the manager who informed us that the staff from the recruitment agency would cease to be used with immediate effect.

People told us that there were, on the whole, enough staff on duty to support them at the times they wanted or needed. One person said staff came when they needed them. Another person said they didn't have to wait for staff. A further person said, "Sometimes if I ring my bell I have to wait – that's if it's lunch time and they're busy." Another person said, "If I want someone I shout and someone soon comes."

We observed that on the day of our inspection, there were sufficient staff on duty and that people received assistance and support when they needed it. We did observe a time when people within the residential

dementia community did not receive support due to the deployment of staff. People would have benefitted from having a member of staff present to assist them and engage with them at breakfast.

It is recommended that the registered provider reviews the deployment of staff within the dementia communities in order that staff are available to engage with people living with dementia at all times.

The home used a dependency tool to decide staffing levels that considered peoples individual needs, the layout of the building and also considered the skill mix of staff required. The manager told us that staffing levels were reviewed weekly or if there were changes in a person's needs. Staffing levels consisted of two nurses and eight care staff of a day and one nurse and four care staff during the night. In addition to this, separate cleaning, kitchen and activity staff were allocated to undertake specific duties. Staff said that staffing levels were sufficient to provide safe care. One said, "Some days are busier than others obviously, but it's fine". Another staff member told us, "Some agency staff are used on nights but not during the day. We have enough staff for sure".

Risks to people were managed safely. When incident and accidents occurred records evidenced that action was taken to minimise the chance of a re-occurrence. For example, one person had begun to fall on a regular basis. It was identified that the person required better shoe support, which was provided. Another person's care plan identified difficulty in swallowing as an issue. The person had been referred to a speech and language therapist for assessment. We noted the risk assessments for the person reflected this and contained an extensive list of food items the person liked and were still safe to eat.

Staff understood risk management and keeping people safe whilst not restricting freedom. One staff member said, "We have done risk assessments which we use to keep people as safe as we can". Another staff member told us, "We can't get rid of risk altogether. Not unless we stop people trying anything which we wouldn't do". Since being in post the manager had implemented an accident log to monitor trends.

Systems and processes were in place to safeguard people from harm. Staff had undertaken adult safeguarding training within the last year. They were able to identify the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy. One staff member told us, "If I saw a colleague doing something they shouldn't I would let my manager know". Another staff member said, "The manager would deal with it I know, but if not I would go to the social workers or you (the Care Quality Commission)". Staff confirmed to us the manager operated an 'open door' policy and that they felt able to share any concerns they may have in confidence. The manager demonstrated knowledge and understanding of safeguarding people and her responsibilities to report concerns to the relevant agencies. Since being in post the manager had obtained easy to read guidance about safeguarding and displayed this in the home in order that people were supported to understand their rights.

Equipment was available in sufficient quantities and used where needed to ensure that people were moved safely and staff were able to describe safe moving and handling techniques. We observed staff supported people to move safely from wheelchairs to armchairs using a hoist. They explained the process to people, telling them what was happening and provided reassurance. Records were in place that confirmed that hoists and slings were checked on a regular basis along with a system to report if equipment was faulty.

Checks on the environment had been completed to ensure it was safe for people. These included safety checks on small portable electrical items, hot water, Legionella, the emergency call bell system and fire safety equipment. Personal emergency evacuation plans were in place for each person that would help them be moved from the home in the event of a fire. These were kept a folder in the reception area of the

home in order that they could be accessed easily in the event of a fire.

Medicines were managed safely at Chestnut View Care Home. At our previous inspection a requirement action was set as medicines were not always managed safely. At this inspection we found that steps had been taken by the provider and the requirement action was met. Staff told us there was yearly training provided in medicines management and records confirmed this. All staff underwent a process of regularly competency checking through direct observation of medicines administration by the manager.

The administration of medicines followed guidance from the Royal Pharmaceutical Society. We noted staff locked the medicine trolley when leaving it unattended and did not sign Medicine Administration Record (MAR) charts until medicines had been taken by the person. There were no gaps in the MAR charts, which were clear and legible. Staff were knowledgeable about the medicines they were giving. We also noted where medicines had been prescribed on PRN 'as needed' basis; staff followed the provider's 'PRN' protocol. This contained information about each medicine prescribed, the reason for administration, the maximum dose allowed and the minimum time between doses. Where the medicine was prescribed as 'one or two' as needed, the staff member had indicated the amount actually administered on the MAR chart.

Three people at the home managed their own medicines. We noted those people's medicines were stored in lockable cupboards in people's rooms, to which the person had access via a key. The provider had undertaken initial and subsequent mental capacity assessments of these people to ensure they remained capable of managing medicines in a safe and effective manner. However, we noted one person had gone out for the day and the door to their room was open. We saw that medicines were on their bedside cabinet, easily accessible to anyone. The person did have a lockable cabinet in their bathroom but this was open and empty. We discussed this with the manager and nominated individual who stated they would ensure that the person's room was locked if they went out in future.

Three people received their medicines covertly, that is without their knowledge or permission. This was done because none of these people possessed the mental capacity to understand the risks associated with consistently refusing to take medicines. They had been assessed prior to this action in a manner consistent with the law. We looked at documentation related to this, including covert administration of medicines forms. They included evidence of why this step needed to be taken. They showed all alternatives had been explored and that a medical practitioner and the person's family if possible had been involved in decision making to ensure it was in the person's best interests.

Requires Improvement

Is the service effective?

Our findings

People said that they were happy with the medical care and attention they received and we found that people's health and care needs were managed effectively. A relative said they had learnt from staff. They noted that staff always told their mum what they were about to do before they did it, like, "We are going to move your leg now." They said they always ensured they did the same after watching and listening to staff. A second relative said, "The nursing is fantastic here. I feel confident X is well cared for."

While in the dementia nursing community we observed one person being nursed in their room. On two separate occasions we observed that they called out for several minutes before a member of staff came and sat with them. The staff who went and sat with the person did not appear confident to support the person with their emotional and psychological needs. We noted that there was little information in care plans for people living with dementia to reflect their specialist emotional and psychological needs. In particular the ways for care staff to support people who were now having difficulty with cognition and communication. The manager showed us life story books she and the activities coordinator had been working on to reflect peoples journey so far and their likes and choices. This was a work in progress and had not been shared with the wider team at the time of our inspection.

It is recommended that the registered provider reviews the guidance and information staff receive in order that staff are competent to support people who live with dementia with all of their emotional and psychological needs.

At our previous inspection a requirement action was set in relation to consent due to a lack of mental capacity assessments and DoLS applications where people lacked capacity to consent to restrictions on their liberty. At this inspection we found that sufficient steps had been taken and the requirement action was met.

People said that they consented to the care they received. 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. Mental capacity assessments were completed for people and their capacity to make decisions had been assumed by staff unless there was a professional assessment to show otherwise. This was in line with the Mental Capacity Act (2005) Code of Practice which guided staff to ensure practice and decisions were made in people's best interests.

Where people lacked capacity to make certain decisions, assessments had been completed and best interest meetings held with external professionals to ensure that decisions were made that protected people's rights whilst keeping them safe. During our inspection we observed staff seeking people's agreement before supporting them and then waiting for a response before acting on their wishes. Staff asked people for consent before assisting them to move, to eat, and before giving them medicines.

Chestnut View Care Home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). 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). The manager understood when an application should be made, how to submit one and the implications of a recent Supreme Court judgement which widened and clarified the definition of a deprivation of liberty. Applications had been made for people who lived at the home as coded locks were in place in the home and some people did not have the capacity to consent to their use. Information about the MCA and DoLS was on display in the home and included an easy read format which the manager had put in place in order to help people to understand their rights.

We saw that least restrictive practices were being followed. However, these were not always recorded in assessments and care plans. The manager said that this would be addressed. Most of the staff we spoke had a good understanding of the MCA, including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. One staff member told us, "The Act is about allowing people to make their own decisions when they can and to protect them when they can't." Some staff could tell us the implications of DoLS for the people they were supporting. Of the 57 staff employed at the home, 17 had received MCA and DoLS training. The shortfall in numbers of staff having undertaken this training had been identified within the quality monitoring systems at the home and further training was planned.

It is recommended that the registered provider reviews its procedures to ensure they evidence that least restrictive practices are recorded.

People said that the food at the home was good and that their dietary needs were met. One person said, "The food and the care here are fantastic." Another said, "The food is good and you get enough. I like the porridge." A third person said, "This morning my food was so hot – just how I like it."

There were separate dining rooms located on each of the floors of the home which helped promote an intimate dining experience for people. We observed that some people choose to eat in the dining rooms and others in their rooms. The pureed food looked well-presented and the meals in general looked appetising. There was a choice of two meals and people had chosen what they wanted to eat the day before. Staff had a list which they referred to for people's choices. This also gave information on who required a pureed meal. However we noted it did not indicate those people who were diabetic. For example, one person in Primrose Suite was diabetic but this was not marked on the sheet. We asked staff about this and they told us the person could eat normal meals.

People who required support to eat were being fed at a nice pace with staff checking whether they were ready for the next mouth full. One staff member asked a person if they'd like pudding, when this person didn't understand the choices the staff member plated up two puddings and showed them. We saw this person didn't eat what they had chosen and staff offered them yoghurt instead which they were happy with. A four week menu was in place that offered people a variety and choice of home cooked meals, desserts and snacks.

Within the dementia communities people had water jugs in their rooms and a drinks trolley was circulated at pre-set times during the morning and afternoon. There was no fresh fruit or snacks available within the dementia community for people to access independently and at times of their choosing. We were informed this was due to one person with specific needs which meant food and drinks could not be left unattended. Menus were not displayed on the tables within the dementia community. Instead staff gave verbal choices of the food on offer. We observed two relatives who regularly supported their family members with their

meals also providing help cutting up the food of others. When doing this one relative informed a member of staff that the meat was tough. The member of staff confirmed this and offered an alternative omelette to the person who declined. The member of staff did not offer any visual aid when offering the alternative which may have helped the person understand what an omelette looked like.

Care plans were in place for managing people's nutritional needs. However, these were generic and did not include information about how to support people who lived with dementia to receive adequate nutrition. Weights were recorded monthly and these were monitored by the clinical lead nurse and manager. Where people required referral to specialist services i.e. speech and language therapy (SaLT) or the dietician this was managed in a timely way. Food and fluid charts were used to monitor that people identified at risk of malnutrition or dehydration received sufficient amounts of food or fluid. Those we sampled evidenced that most people were having sufficient fluid daily. However, we did note one person's care records contained different recommended fluid intake targets in different parts of their plans ranging from 1 litre daily to 1.5 litres daily and that other people's monitoring charts had not always been totalled. This meant that appropriate action might not always been taken promptly as the home would not know if the person was at risk of dehydration. Prescribed food supplements were in place for people manage weight loss.

It is recommended that the registered provider researches and implements care management systems and dining experiences that are dementia specific for people who are living with dementia within the home.

At our previous inspection a requirement action was set due to a lack of training and formal supervision provided to staff. At this inspection we found that sufficient steps had been taken and the requirement action was met.

Staff were skilled and experienced to care and support people to have a good quality of life. New staff completed an induction programme at the start of their employment that followed nationally recognised standards. One staff member said of their induction, "It was good. No problem at all. I wasn't left to my own devices and felt well supported."

Staff were trained in areas that included fire safety, first aid, food hygiene, infection control, moving and handling, safeguarding and health and safety. A training programme was in place that included courses that were relevant to the needs of people who lived at Chestnut View Care Home. These included dementia care and wound care. The manager had also arranged for herself and another member of staff to attend a training session in February on nutrition, hydration, puree meals, food fortification and dementia friendly meals organised by the Local Clinical Commissioning Group. The manager explained that they would then cascade any knowledge gained to other staff who worked at the home. She had also arranged for another member of staff to attend a conference in April on serious incidents. This showed a commitment by the manager to ensure that staff were provided with training that enabled them to support people appropriately. With regard to training one member of staff told us, "We do quite a lot of training." Another staff member told us, "I've learned a lot. In fact I learn every day."

Staff received support to understand their roles and responsibilities through supervision and an annual appraisal. Supervision consisted of individual one to one sessions and group staff meetings. Staff said that they were fully supported. One staff member said, "Supervision is good. We talk about my progress and what I need for the future." Another staff member told us, "I can say what I want and the manager always listens." Since being in post the manager had implemented a supervision and appraisal matrix for planning and monitoring staff received regular, formal support.

The provider involved a wide range of external health and social care professionals in the care of people.

These included speech and language therapists, Macmillan Nurses and hospital consultants. The advice and guidance given by these professionals was followed and documented.

Effort had been made to ensure the design and decoration of the home was suitable for people who lived with dementia. The dementia care communities were brightly painted with different coloured doors to bedrooms to support people with orientation and to find their own rooms. Bathroom and toilet doors were uniformly blue and signage included pictures and words again to help people to identify the toilets. The dedicated communal toilets had toilet seats of a contrasting colour for those people who may have difficulty identifying the toilet to changes in visual perception. Some rooms had filled memory boxes outside again to help people with orientation and reminiscence. There were murals and interesting objects on the walls for people to touch and feel and for reminiscence.

Good

Is the service caring?

Our findings

People said that they were treated with kindness and respect. One person said, "It's nice here. The staff are kind and I'm well looked after. I wouldn't want to leave." A second person said, "I am very friendly with the staff. We have a laugh." Two further people said staff were, "Kind and caring" and treated them with respect. One went on to say, "Everyone is friendly and the girls are good." Another said, "The staff are so kind to me. Nothing is a trouble." An external health and social care professional wrote and informed us, 'There is a feeling of warmth and wanting and needing to support people'. A relative said, "The staff here are brilliant, so caring and concerned."

The homes aims and objectives and philosophy of care included, 'We strive to preserve and maintain dignity, individuality and privacy of our residents and remain sensitive to each person's ever- changing needs'. We found that staff understood these and reflected this in the care they provided to people. We observed interactions by staff to people that were warm, positive, respectful and friendly whilst remaining professional. When staff used non-verbal ways to communicate with people they ensured they were at the same eye level to engage with people. Many of the staff had worked at the home for several years and it was apparent that positive, caring relationships had been developed with people. Staff had a smile on their face every time they approached or spoke with someone.

People were supported to express their views and to be involved in making decisions about their care and support. One person said, "I can make my own decisions about my care." An external health and social care professional wrote and informed us, 'There is always something going on and clients and relatives are always involved'. We observed that staff routinely checked that people were happy with the support being offered. People told us they could get up when they wished and if they wanted a lie in staff would respect this and come back later.

Care records evidenced that people or their representatives had involvement in aspects of care planning and risk management. We noted people and/or their families were invited to be involved in care planning from admission onwards. Consequently, there were opportunities to alter the care plans if the person did not feel they reflected their care needs accurately.

The manager had arranged for a newsletter to be published in order to inform people of events and occurrences at the home. This included the use of photographs to aid communication with people who lived with dementia. She had also given each of the dining rooms at the home the name of a flower. The manager explained this was, "To make the building feel more homely for people."

Staff understood the importance of respecting people's privacy and dignity and of promoting independence. One staff member told us, "We get to know them. We learn about what they've done and been in the past so we see them as real people, not just someone to be physically cared for." Staff were seen to discreetly advise people when they required attention to their personal care and this was always provided in private. We observed that staff knocked on people's doors before entering. During lunch staff ensured people's mouths were clean which helped promote their dignity.

Families were supported with kindness and consideration when their relatives were reaching the end of their life. We were told about the recent experience of a person who died during the weekend prior to our inspection. The person's family and their dog were welcomed into the home and a room was allocated so that they could stay. For many hours a family member and the dog would spend time with their loved one during the last few weeks, days and hours before their death. The manager reflected on how caring and appropriate this was for both the person at the end of their life and those on the journey to bereavement.

Good

Is the service responsive?

Our findings

People said that staff took appropriate action in response to changes in people's needs. An external health and social care professional wrote and informed us, 'It is responsive to the needs of clients and relatives'.

People's needs were assessed and care and treatment was planned and delivered to reflect their individual care plan. For example, we noted one person was receiving end of life care. There was evidence of appropriate involvement of external agencies, such as Macmillan Nurses to ensure up to date and appropriate care. The risk assessments also focused on issues important to the person, such as pain relief, involvement of family members and maintenance of dignity and privacy.

Peoples care records contained information about people's care needs, for example, in the management of the risks associated with challenging behaviour and chronic illness. The care plans also contained information about personal histories and likes and dislikes. People's choices and preferences were documented. The daily records showed that these were taken into account when people received care, for example, in their choices of activities. Care planning and individual risk assessments were reviewed on a regular basis. Some included evidence that people or their representatives' had been involved and others did not. The manager had identified this as an area of improvement and informed people and their relatives in a meeting held in January that action would be taken to ensure everyone had the opportunity be involved.

Staff understood about providing personalised care to people. One staff member told us, "It's really about having the resident at the centre of things. The care is for them and might not suit someone else." Another staff member said, "I think it's trying to make this place a home from home so people will be comfortable."

People said that they were happy with the choice of activities on offer. One person said, "There is always something going on." A second said, "I join in the activities. They (staff) tell me what's going on and I go up if I fancy it and spend an hour there." During our inspection we observed six people in one lounge area having tea and chatting together with the activities co-ordinator and a visitor who had come in with a dog. We saw that information about forthcoming activities was left in the lounge area for people. Three people mentioned they would like staff to ensure they knew about the activities going on as they didn't always remember and needed reminding. One said, "I don't know if I've missed them this morning. I usually go along." Activities that people could participate in included quizzes, chair football, coffee at the local Methodist church, rambling, reviews of newspapers, bingo and arts and crafts.

People were supported to go out into the local community and to maintain links with people who were important to them. A relative said, "I come and help take people out in the van. The fresh air is great for raising spirits. We also take some people to the Methodist church every Wednesday." One person told us how they went across the road to friends in the village and that their daughter came in each day to visit them. A relative informed us that they were always made welcome and confirmed that staff supported their family member to maintain contact with them.

Each person's bedroom was decorated differently to reflect their individual tastes. We were shown bathrooms that the manager had arranged to be decorated in a style that was less clinical than they previously were. The manager explained that access to the garden was also going to be improved once a planning application had been approved by the local council.

People were supported to raise concerns and complaints. One person said, "If I wanted to complain I'd go down and speak to the manager." Staff were seen spending time with people on an informal, relaxed basis and not just when they were supporting people with tasks. During our visit we observed staff assessing if people were happy as part of everyday routines that were taking place.

Information of what to do in the event of needing to make a complaint was displayed in the home. The complaints procedure included the contact details of other agencies that people could talk to if they had a concern. These included the CQC. A record was in place of complaints received and the manager had introduced a complaints log that included a record of actions taken to investigate the complaint and outcome. The record introduced by the manager demonstrated that when issues were raised prompt action had been taken to resolve these. For example, when a person raised concerns verbally to the manager about a member of staff. The manager arranged for a meeting with the member of staff concerned the same day and fed back to the complainant the following day the actions they had taken. Records confirmed the person was happy with the manager's actions. During the week prior to our inspection the manager had also arranged for a suggestions box to be installed at the entrance of the home as another way of people raising concerns.

Requires Improvement

Is the service well-led?

Our findings

People said that the home was well- led and that the new manager was approachable. One relative said, "X (manager) is brilliant. She has raised the spirits and you can see she really enjoys her job. She is very nice to me." A second relative said, "The manager has lightened things up. She is very professional and you get straight answers from her." Two people said they didn't see the manager much. One person said the manager was, "Very nice" and they'd seen her two or three times.

The manager was aware of the need to create a positive culture at Chestnut View Care Home and had started to take steps to ensure this was inclusive and empowering. The manager had been in post since December 2015. Everyone that we spoke with said that the manager was a good role model and that she was implementing and driving positive changes at the home. Staff were motivated and told us that they felt fully supported and that they received regular support and advice. One member of staff said, "This new manager is more hands on and much easier to talk to. That makes things a lot simpler."

Records and discussions with staff confirmed that there had been an increase in staff meetings and people were now being encouraged to be actively involved in making decisions about the service provided. For example, a staff meeting in December 2015 was held where staff were asked to give their views and opinions on what was working well at the home and areas that they thought could be developed. The findings from the feedback sheets completed by staff had not been collated and evaluated at the time of our inspection.

The manager placed a strong emphasis on continually striving to improve. She was passionate about providing a quality service to people. She told us, "I'm motivated and passionate about care. I have lots of things I want to implement and want people on board." The manager had reinstated residents/relatives meetings in order to obtain the views of people. One meeting had been held and a schedule put in place for others to take place. During the meeting the manager informed people that she intended to set up a dementia support group for relatives of people. This showed that the manager considered relatives as well as people who live at the home. The manager had also completed a mealtime experience audit that included an observation of the meal in order to assess the experiences of people who may not be able to verbalise their views.

We asked staff about the vision and values of the home. We asked the question, "What is the purpose of the home and what does it offer to people?" One staff member said, "It's a happy, caring place. The staff are happy and so are the residents." Another staff member told us, "We offer safety, warmth and a place to call home." The manager was aware of the attitudes, values and behaviours of staff. She monitored these when completing audits and during staff supervisions and staff meetings.

A range of quality assurance audits were completed by the manager and representatives of the provider that helped ensure quality standards were maintained and legislation complied with. These included audits of medicines, accidents and incidents, health and safety, care records and staffing. The audit system had been reviewed and was linked to the Fundamental Standards. The provider had recently commissioned the services of an external consultant for a three month period to enhance the monitoring systems and to offer

further support to the manager. As a result of this a, 'Continuous Improvement Plan' (CIP) had been implemented that was being used by the manager to ensure timely action was taken to make improvements at the service. The majority of areas that we identified during our inspection that would benefit from improvement had already been identified within the CIP which included dates when the manager aimed to address these in the near future.

Surveys were organised and managed from the providers central office and sent to people on a monthly basis, with the findings forwarded to the home. The manager was unable to show us the findings from the latest surveys. She said that she would arrange for the findings to be sent to us.

The provider had implemented a Duty of Candour policy on the 2 January 2016. Duty of candour forms part of a new regulation which came into force in April 2015. It states that providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Providers must have an open and honest culture at all levels within their organisation and have systems in place for knowing about notifiable safety incidents .The provider must also keep written records and offer reasonable support to the patient or service user in relation to the incident. Staff that we spoke with were not able to describe its relevance and application. The manager demonstrated understanding of the policy and reflected an open and transparent demeanour throughout our inspection.