Care Quality Commission

Stonehaven (Healthcare) Ltd

Chollacott House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Inadequate
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

The inspection visits took place on 13, 22 and 23 January 2015 and were unannounced.

Chollacott House is a nursing home providing nursing and personal care to a maximum of 42 people. The home is divided into the main home and Drake Unit which accommodates to a maximum of 10 people, some with neurological conditions. There were 34 people resident at the time of the inspection.

The service had a 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 of Health and Social Care Act and associated Regulations about how the service is run. As

Summary of findings

the registered manager is not a registered nurse the home employed a lead clinical nurse but that person does not hold the legal responsibilities held by the registered persons.

At the last inspection on 16 May 2013 we found the home was meeting all the required standards we checked.

The assessment, planning and delivery of some people's care were not sufficient, particularly where their needs were complex and a health condition required monitoring to promote their health. There were not sufficient nurses to adequately oversee the care and treatment of people with nursing needs.

Medicines management was not robust and the delivery of medicines was not always in accordance with people's prescriptions. On two occasions, people's pain relieving patches had not been changed on the correct day.

Not all risks were being managed and arrangements for communication sometimes failed; this had led to one person's lunch being missed and another person's blood test overlooked. One person had tried to climb over a bedrail but the information was not passed on quickly to protect them from the risk. Another person was given a flu injection at Chollacott House when they had recently been given one by a community nurse.

The arrangements for reviewing the standard of service had failed in that the safety concerns we found had not been identified by the management at the home or provider organisation. However, staff and health and social care professionals spoke of the openness and strong management approach of the registered manager.

Staff were trained and competent in delivering end of life care with dignity. Some staff felt it was what the home did best.

People were protected from abuse through the home's safeguarding policies and procedures. Staff knew how to respond if they had any concerns which might indicate abuse had occurred. People were involved in decisions about their care and the staff understood legal requirements to make sure people's rights were protected.

People were satisfied with the standard of food provided. The menu was varied and well balanced. The chef was knowledgeable about providing specialist diets to meet people's individual needs and preferences.

People's views were regularly sought and they were able to help shape the service they received. This included the food options, activities and entertainment. Complaints were investigated and followed through to people's satisfaction where this was possible.

Staff were very happy with the training they received and the training options available to them. They spoke of feeling well supported through access to the registered manager, staff meetings and staff supervision arrangements. The staff recruitment arrangements ensured staff unsuitable to work in a care home for older people were unlikely to be recruited.

Staff were kind, friendly, treated people with respect and upheld their dignity. They spoke with passion about the care they provided and the people they cared for. One person said "The staff, from management down, are all respectful and willing to communicate without intrusion."

We found breaches of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Inadequate

People's medicines were not always handled in a safe way. It was not always clear what medicines had been given and some medicines had not been given as prescribed.

Staffing deployment did not ensure people would receive the level of care they required. This mostly related to a lack of qualified nurses for the size of the home and the complexity of people's needs.

The systems for identifying and managing risks did not always identify level of risks, such as the safe use of bedsides.

People were protected from abuse through the policies and procedures in places.

Recruitment practice was robust and protected people from staff who might not be suitable to work in a care home environment.

Is the service effective?
The service was effective.

Good

People had a well-balanced and nutritious menu to choose from and were able to influence the food options available to them. People fluid needs were met.

Staff were very satisfied with the standards of training and support they received and were competent and supported to deliver a high standard of personal care to people.

People were fully involved in decisions about their care and the staff understood legal requirements to make sure people's rights were protected.

Is the service caring?
The service was caring.

Good

People received kind, considerate and respectful care from staff who spoke with passion about their work and the people they cared for.

People's views were sought and listened to. They were able to help shape the service they received.

Staff were trained and competent in delivering end of life care with dignity. Some staff felt it was what the home did best.

Is the service responsive?
The service was not always responsive.

Requires Improvement

Summary of findings

A lack of depth of information during assessment, care planning and health monitoring had led to people's needs not always being responded to, particularly nursing issues.

There were many ways in which people were able to make their views known and their opinion helped to shape the menu, activities, equipment and furnishings.

Complaints were investigated and followed through to people's satisfaction where this was possible.

Is the service well-led?

The service was not always well led.

Inadequate arrangements for managing and communicating information at Chollacott House put people at risk.

Regular audits, such as medicines and care plans, had not ensured those arrangements were safe and ensured the care required was delivered.

The open approach of the registered manager and the efficiency of the deputy manager were expressed by most people and staff. People spoke highly of the management of the home and the support of the provider organisation.

Requires Improvement

Chollacott House Nursing 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.

The inspection visits took place on 13, 22 and 23 January 2015. The visits were unannounced. The inspection team consisted of three inspectors, one a pharmacist.

Before the inspection we looked at information we held about the home, which included incident notifications they had sent us. A notification is information about important events which the service is required to tell us about by law. We spoke to three health care professionals who gave their opinion of the service. We requested the current Statement of Purpose (SOP) from the home. A SOP describes the service the home is intending to provide.

Not everyone was able to verbally share with us their experiences of life at the home. This was because of their dementia/ complex needs. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with eight of the 34 people who used the service and five people's families to obtain their views about the service provided in the home. We interviewed 10 staff and the registered and deputy managers. We looked at records which related to six people's individual care planning. We looked at 28 medicine records, the recruitment files for four staff and documents which related to the running of the home such as records of meetings, weekly and monthly checks.

Following the inspection visit we asked the home to send us the records of provider monitoring visits.

Inadequate

Is the service safe?

Our findings

People's medicines were not always handled in a safe way. It was not possible to be sure from the records whether people received their medicines in the way they were prescribed for them. We found that there were one or more gaps on 10 people's medicine charts where it was not recorded whether a dose of a regularly prescribed medicine had been given or not. Separate recording charts were used for application of medicated patches, but it was not always recorded on these charts when patches were applied or removed, potentially causing confusion over when patches were due to be changed. On two occasions, people's pain relieving patches had not been changed on the correct day. We found a dose of one medicine still in its blister pack, although this dose had been signed on the person's chart to say it had been given.

It was not possible to be sure whether people had received the creams and externals items prescribed for them. There were sheets for creams and any external items in people's rooms which gave clear instructions for care staff on how and where these were to be applied. However, there were no records kept of many external items applied.

The records for some medicines prescribed related to a syringe driver, which is a method for administering specific medicines. There were multiple records and entries on those medicines charts leading to confusion as to where to record what was given. We found that the medicines were being given in accordance with the range in the prescription, however the unclear records increased the risk of a potential error occurring.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Medicines were given in a caring way. The nurse spent time with people making sure their medicines were taken correctly. There was no-one who looked after their own medicines at the time of this inspection, but we were told that people could do this if it had been assessed as safe for them.

We found that medicines were stored safely and securely. The registered manager talked about the arrangements for monitoring the temperatures at which medicines were stored to make sure they would be safe and effective. There were suitable arrangements for storage and recording of controlled drugs, and for the ordering, receipt and disposal of medicines.

Identified risks were not always managed to keep people safe. One person's file included a record from a nurse stating: "I found from carers about (the person) trying to climb the bed rails". The deputy manager was unable to establish when the carer had witnessed this event and we saw from the daily hand over records the nurse in question did not pass the information on. This meant the use of bedrails for this person was not reviewed in light of the danger.

Individual risks were not always well managed. For example, a safety and risk assessment in one person's file stated "All staff will be trained in awareness of Huntingdon's disease but a care worker on the unit at that time said they had not received this training. A second example was a pressure damage risk assessment which was unclear in its outcomes and it did not include the person's name.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was no indication that staffing level on the Drake Unit had been assessed or monitored to make sure they were flexible and met the people's individual needs and to keep them safe. One person's family told us they were happy there was a high staff ratio on the Drake Unit. However, when we arrived on the unit we found a person coming out of their room, wearing only underclothes, no footwear, pushing a chair with bedding on it. The room had breakfast spilled on the carpet, there was faeces smeared on a chair and they were distressed. We asked a member of cleaning staff if they could locate a care worker but were told the care workers were busy. A few minutes' later two male care workers arrived. Later there were times when care workers did not appear to be busy although they were not using their time to engage with the people they were caring for. At one point the only staff member on the unit was an agency staff. They told us they had worked at the home several times.

The deployment of staff negatively affected the care people received. Some people required the skills of a qualified nurse but the registered nurse on duty spent very little time on the Drake Unit where some people's needs were complex and of a nursing nature. An occupational therapist

Inadequate

Is the service safe?

also told us that when they visited the home on 9 December 2014 there was no nurse on the Drake Unit. We saw that one person had received their medicines one hour late on one occasion, which had made them very anxious, as stated in their care plan that it would. The registered nurse on duty told us not all medicines could be given at exactly the right time because they had to administer them to the whole home. Two nurses told us it would take at least between 8.30am and 11am to deliver medicines throughout the home, leaving time for little else on a morning shift. A nurse told us, "Very, very hard with one nurse. You can cope but you go home thinking 'that was scary'." Another nurse said, "I'm very hot on the palliative care but one nurse (on duty) cannot give the extra care to the dying; we try our best." Following our inspection visits we were told the numbers of nurses on duty was to be increased.

People using the service who had less complex needs felt there were plenty of staff to attend to them and people were assisted to, and in, the main lounge on the ground floor on a regular basis. However, staffing arrangements did not always ensure people's needs were met in a timely manner. A social worker told us that when the paramedics arrived on 18 December 2014 in response to an emergency call it was they who opened the door for them and they were unable to find staff to inform.

The home's SOP stated it was the registered manager's judgement as to the staffing levels and skills. An indication of staffing when the home was full described the need for one registered nurse on duty over the 24 hours. Seven care workers for the morning, six for the afternoon, and three for the night time, a cook/chef, cleaner/housekeeper and laundry staff during the mornings. Staffing for the Drake Unit depended on occupancy but was to include a registered nurse 9am to 3pm week days but not weekends although a registered mental nurse was to work night times. On the Drake Unit those staffing levels and skills were not being achieved. The Drake Unit did benefit from regular visits by a psychiatrist employed by the provider organisation but there was no registered mental nurse working at the home to direct the care and treatment for the people whose illness included mental health needs.

Before the inspection visits health and social care professionals had told us they did not always find a member of staff easily when they visited Chollacott House.

Asked what could be improved one person's family told us, "More staff. Sometimes the buzzers are going off all the time but 90% of the time staff come within a reasonable time."

This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff demonstrated an understanding of what might constitute abuse and knew where they should go to report any concerns they might have. For example, staff knew to report concerns to the registered manager. They also knew where information about reporting concerns externally, such as the local authority, police and the Care Quality Commission (CQC), was displayed. Staff had received "one off" safeguarding training but records showed that for some staff this was now several years ago.

The registered manager demonstrated a clear understanding of their safeguarding role and responsibilities and we had knowledge that they put those responsibilities into action as needed. They explained the importance of working closely with commissioners, the local authority and relevant health and social care professionals on an on-going basis. An example was an incident where a temporary worker at the home was found to be unsuitable and this was dealt with promptly. The registered manager said, "I talk to the (social services manager) often about such concerns."

People told us they felt safe at Chollacott House one saying, "On the whole very, very good."

There were recruitment and selection processes in place and an on line system for checking recruitment was complete before staff started at the home. Recruitment files of recently recruited staff included completed application forms, interview records and confirmation that nursing staff were correctly registered to provide nursing care. In addition, pre-employment checks were completed, which included references from previous employers. A care worker confirmed that she had been telephoned to check her references. However, some were open references and the registered manager had not taken the additional step of contacting the referee which would have made that recruitment more robust. The registered manager said that staff had, however, been recommended by a current staff member. Health screening and Disclosure and Barring Service (DBS) checks were completed. The DBS helps employers make safer recruitment decisions and helps

Inadequate

Is the service safe?

prevent unsuitable people from working with people who use care and support services. This demonstrated that appropriate checks were undertaken before staff began work with people using the service. A recently recruited staff member confirmed they had not started to work with people until their recruitment checks were completed.

Good

Is the service effective?

Our findings

People received a nutritious and varied diet. People were generally satisfied with the standard of food provided. Their comments included, "Lovely"; "Alright, not much choice but enough variety for me" and "No complaints. Good. I cannot face a great plateful of food and usually they don't present this." Staff told us there were usually two choices of food for lunch adding, "We find out and ask people and the chefs are pretty accommodating if other foods are wanted."

People influenced the menus. Regular resident meetings included discussion about the menu and people had the opportunity to offer menu suggests. For example, it was raised that there had not been a junket option for a while and It was noted that there had been an increase in wine with the meals since Christmas, which was a cause of mirth.

The chef told us they were qualified and very experienced in their role. They ordered the foods and designed the menus. There was a four week menu rotation. Breakfast options included fresh fruit, toast and preserves or a cooked meal. Lunch options included, lamb casserole, curry and rice, broccoli and bacon tart and omelettes. Tea included soups, sandwiches, scotch eggs and corn beef hash. Lunch and tea included a desert. We were shown the list of people's menu choices for that day. Hot and cold drinks were regularly offered and provided.

Specialist dietary needs were provided for. The chef explained how adjustments were made for specialist diets and a speech and language therapist confirmed the home sought their advice where there might be a choking risk.

Staff were complimentary about the training they received; one saying that training was what the home did best. A programme of mandatory training for staff included first aid, dementia awareness, infection control, nutrition and diet and protection of people from abuse. However, according to the programme those training sessions were "one off" and via social care television. Some training was recorded as having been done as far back as 2006 and there was no refresher training in the subjects.

Training in moving people safely and fire safety and fire safety were practical training provided yearly. The fire alarm sounded during our visit and each of the staff responded calmly and as expected. There was three yearly first aid practical training and a "one off" practical medication training listed. Some care staff were undertaking diplomas, levels two to five, in social care. Nursing staff had received training in relation to their work. For example, the use of pain relieving equipment and the verification of death. Two senior care workers, including the deputy manager had completed a certified course on Huntingdon's Disease. No nursing staff had received this training although some had received an 'overview of Huntingdon's Disease' and a representative of the organisation told us they had visited three times to talk to staff who had been receptive to the information.

Staff received an induction when new to the home. A recently recruited staff member did not think she had a formally recorded induction but the deputy manager said each new staff member did the nationally recognised induction programme but the records were kept separately from the staff file so staff could access them. The new staff confirmed a 12 hour induction day and said they worked with a senior care worker "constantly" until they knew what they were doing. Two care workers, who said they were also new to care work, told us their training was "perfect" adding that nursing staff and senior care workers trained them to meet people's individual needs, such as catheter and stoma care. A senior care worker said that the induction process was over a three months period until the staff member was competent.

There was a delegated system of staff supervision and staff confirmed they received supervision of their work, two saying this was monthly. They added that they could talk to colleagues about work issues. However, there was no clinical supervision in place for the clinical lead.

Care files showed people had access to advice and treatment from health care professionals. For example, in one file the person had their medicines reviewed, a speech and language assessment and monthly psychiatric review. One person's family told us, "The home is very happy to call in the GP or psychiatrist etc. and they let us know." Another person's family told us the care was "very, very good." Care workers, without exception, felt the standard of care they delivered was very high. One said, "The care is very good. We work really well." People's care needs were generally met. For example, no people had pressure damage at the time of the inspection visits.

Staff demonstrated an understanding of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and how these applied to their practice. The MCA provides the legal framework to assess people's

Good

Is the service effective?

capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. People's families confirmed this to us.

Where people did not have the capacity to make particular decisions about their care and support, due to their health condition, there was evidence of understanding by staff of mental capacity and promoting people's decision making. However, records showed the outcome of MCA assessments but not how people's capacity to make a decision had been assessed.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The home had made 17 applications to deprive people of their liberty following a Supreme Court judgement on 19 March 2014 which had widened and clarified the definition of deprivation of liberty. Those applications had not yet been assessed by the local authority and in the meantime the staff continued to make decisions in people's best interest with involving of people who know them best, usually family.

Good

Is the service caring?

Our findings

Staff were seen engaging with people in a friendly and respectful manner. For example, the chef brought drinks to the lounge and said, “There you are (and their name)”, “Cup of tea (and their name)?”, “Cup of tea or cup of coffee (and their name)?” and “Morning everyone.” One person told us, “The girls who look after us are very good, very helpful and always here. There’s willingness and they enjoy helping other people.” Another person said, “The caring aspect is what they do best.” One person’s family said, “Individually everyone is caring and they are lovely people.” Another person’s family said, “I couldn’t be happier with the staff. Absolutely kind and polite.”

Staff described people’s individual likes and dislikes. One told us, “We are very warm, people and residents see this. We have a natural caring for people. If somebody is sad we recognised it because we see our residents every day.” They told us they would report to the senior care worker if nobody came to visit people and they might be lonely.

People were involved in planning their care. One person had signed to agree they had capacity, had read their care plan updates and agreed with the contents. They had also given permission for staff to administer their medicines on their behalf. They told us staff respected their privacy and treated them with respect. For example, they preferred to eat in private and the staff facilitated this for them. There was information about preferred male care workers but also included the names of female carers they would allow to attend them if male care workers were unavailable.

People were treated with respect. Staff respected people’s opinions and sought their views. One person told us, “The staff, from management down are all respectful; willing to communicate without intrusion.” Regular residents’ meetings were held to discuss such issues as entertainment, staffing, menu options and the standard of food. The hot topic the day of our inspection was a new, high tech, toilet about to be ordered. Some people’s files included “This is me” information which included personalised information about them, examples being important routines, what upset them, sleep patterns and personal care preferences.

People’s dignity was upheld. They were supported to maintain their individuality and present as they chose to. They had the dignity of being consulted about their care.

People’s needs at the end of their life were addressed. Some staff had undertaken an 18 month training with a local hospice to ensure they understood how to provide caring and respectful end of life care. Nursing staff had received training in pain relief methods and associated training.

Records, which included details of what treatment one person wished to refuse toward the end of their life, had been comprehensively completed and showed the involvement of a GP, the person and their family in the decisions. However, that level of information was not consistent as some documents relating to end of life decisions were not complete. Another person’s family confirmed the home was in receipt of a document (Lasting Power of Attorney) which gave the family permission to act on the person’s behalf.

Two staff members felt that end of life care was what the home did best. One talked of the “privilege” of providing that care and gave an example of taking one person into the town for an ice cream as this was a request they had made. Asked how staff found the time for that level of care the staff member said “we make it.”

Requires Improvement

Is the service responsive?

Our findings

Records were not always complete or fit for purpose. These included nursing records, which were not always managed according to the Nursing and Midwifery Council (MNC) guidelines, their value as legal documents therefore reduced. Examples included lack of signatures on documents.

Care plans were not comprehensive. Each person had a care plan, which is a tool used to inform and direct staff about people's health and social care needs following an assessment of those needs. One person's family said they were able to be involved in the plan initially. The deputy manager said that care plan reviews were always discussed with the person using the service.

Care plans included information about the person's personal history, preferences and interests; they did not include any goals or aspirations developed with the person and were not suitable in their current format for people with complex needs. For example, they did not include the monitoring which would be required for complex conditions, such as diabetes and Huntingdon's Disease. One plan, where a person used a frame to assist them walking and was vulnerable to weight loss, did not include a moving and handling plan to inform staff how to assist them to move safely or an assessment of their vulnerability to pressure damage. Whilst the plans were reviewed monthly and were person centred in their approach, they were not plans of how the person's needs were to be met. All care plans, for people receiving personal care and/or nursing care, were reviewed by the registered manager, who is not medically qualified. They may not, therefore, have the depth of knowledge required for planning the care for people who receive nursing care and treatment.

This is a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Assessment of people's needs were not always sufficiently comprehensive, in particular where people had complex and/or nursing needs. Some assessments were adequate for the needs of the person and one person's family said they were present for the assessment and were "very impressed" with the deputy manager's bedside manner. Some assessments had been undertaken without the involvement of a qualified nurse. This may have contributed to a lack of detail, which increased the potential for risk once the person was admitted. In addition, health care professionals in the community, who might know a person's needs well, were not always asked to contribute information. In one case this led to a person being given a second influenza injection (flu jab) shortly after admission to the Chollacott House.

One person's care plan provided detail of how their food and meal times were to be managed to protect them from choking and that person was given their lunch as the information described. However, where the monitoring of dietary input was critical to one person's health the arrangements for that monitoring did not protect them. For example, their care plan stated staff should record whether the person had eaten all, three quarters, half, a quarter or none of their meal but there was no indication of how large the quantities of meal were or their calorific value. We were given this information following the inspection but did not see it in use. A speech and language therapist had suggested a daily intake of 1900 calories for this person as they were at risk of weight loss, but this was not being checked and the meal the person had during our visit was small. Another person's care plan stated they should be "reminded to drink". When we first met them they were shouting out asking for a drink. A third person's care plan did not cover the areas necessary for the safety of a person with diabetes, those being blood monitoring, attendance at diabetic clinic, eyesight and foot monitoring.

Where a person had a medical condition, with associated risks and treatment needs, the lack of information posed a risk. Health care professionals told us this had led to "significant nursing issues" being missed for one person and a lack of "nursing oversight" of their care and treatment, which adversely affected their health and well-being. This included poor practice in the positioning of a catheter bag, loss of weight and not recognising when a medicine, which lowers the heart rate, needed to be reviewed. Monitoring records were used but were sometimes of limited value. An occupational therapist felt the completion of food, fluid and positioning charts were of concern for one person. Two care workers told us "We forget to complete them but 99% are completed correctly."

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Where people required only support with their personal care, and could communicate their needs on a day to day basis, or they had been at the home for some time, the

Requires Improvement

Is the service responsive?

information in the care plans was good and the people were very satisfied with their care. One person said, "The care is very good, but I need very little attention". A senior care worker felt the standard of care for people with dementia was especially good. They based this on how well people's continence needs were met through "prompting and encouragement", which we had observed during our visits. They also commented how well the environment supported people's independence. For example, different coloured doors in people's rooms to help them find their toilet.

Staff demonstrated considerable knowledge of some people who used the service. For example, one person was in their bedclothes sitting on their bed at midday. Two care workers confirmed the person liked to get up after 11am and if disturbed earlier "Gets very upset." Another person, with complex needs, had detailed information about their positioning and moving plan displayed in their room. They appeared well cared for.

The home arranged for entertainment and activities of interest to people. One person told us she "always goes to support" events in the main lounge, such as a fashion show or 'sing song'. People had used the organisation's mini bus for some outings and hand bell ringers, music and movement and the Town Crier had entertained them at Christmas. At a meeting on 23 January 2015 people were encouraged to give their opinion of the events and suggest new activities. Volunteers from a local school were regular visitors to the home to assist with quizzes, films, bingo and pampering sessions. People had the benefit of a hairdressing salon; pamper sessions and a café area.

People were encouraged to give their views and raise any issues of concern or complaint. At the November 2014 resident meeting one person complained their tea was cold that morning and the registered manager advised them to "ring the bell and complain straight away." One person told us they would take any issues to a senior member of staff, adding they had nothing to complaint about. Staff members appeared open to any issues and ready to take action where required. People were made aware of the complaints procedure and where there had been a complaint it had been investigated and a response provided within the stated timescale.

There were arrangements for some people to have advocacy where this friendship and support would be of value to them. A person from the Huntingdon's Disease Society was visiting one person during our inspection.

Requires Improvement

Is the service well-led?

Our findings

The delegation of roles and responsibilities at Chollacott House were clear, but not always effective. The day to day running of Chollacott House was managed by a registered manager who is not a qualified nurse. The deputy manager has advanced qualifications in care but is not a qualified nurse. The deputy manager oversees the day to day work of care workers and other tasks, such as investigating complaints, which may be related to nursing issues. The home employed a clinical nurse lead to oversee the nursing required at the home and they answered to the registered manager. The provider organisation arranged for some quality monitoring checks to be completed by a nurse manager from another of the organisation's home's, but these had not identified where some of the home's systems were failing.

People at Chollacott House benefit from a culture of respect and the 'can-do' attitude of staff and management, who want to provide a good service for the people in their care. However, standards have not always been effective.

The arrangements for managing and communicating information at Chollacott House put people at risk. For example, lack of communication between chefs had led to one person's lunch being missed. The person had been able to ask staff what had happened to their meal; many people using the service would be unable to do so. A second example was a care worker not immediately communicating when a person tried to climb a bedrail and then the nurse they informed not passing the information on. Information was not always available or well organised. For example, there was no record of a blood test a GP had requested for a diabetic person. A social worker told us they could not find "really important things" when they had visited the home. We saw there was a communication book in use which informed care workers of some things, such as when they needed to read an updated care plan.

There were weekly and monthly checks completed by the registered manager. These included staff induction, supervision and meetings, safeguarding issues, cleanliness, fire safety and laundry. Actions required were signed off when completed, an example being updated care plans. There were health and safety checks completed by the handyman/maintenance department on a regular basis. The clinical lead completed monthly checks, such as first aid kits, lifting equipment and the condition of personal protective clothing for staff. However, the quality monitoring arrangements at the home had not identified where improvement was required to keep people safe.

Arrangements for accident prevention and monitoring were not robust. There were three accident books produced when we asked to see accident records. The deputy manager said this must be why staff kept asking her for a new book, indicating there were more in use than there should have been. The accidents recorded in them did not always tally with the records of accidents written in the daily records of people's care. This would compromise any audit of accidents in the home. An audit of accidents during January 2015 showed there had been 14 un-witnessed falls during that month and one witnessed fall. The audit looked at falls per person, whether day or night time and whether there was an injury.

The registered manager was unaware of their legal obligation to notify us of serious injuries. For example, one person had a serious accident on 18 December 2014 and required a hospital visit, but we were not notified. However, the registered manager makes regular contact with the Care Quality Commission providing information, such as the results of the home's surveys, and records of investigations.

Some people with nursing/complex needs were not receiving the nursing care they required due to the arrangements for staff allocation and roles. This was under review toward the end of our inspection. A nurse told us, "The one nurse (issue) is being addressed." Health care professionals spoke of the registered manager's openness and strong management approach. However, they were in agreement that she was making (nursing) decisions she was not qualified to make and she was unable to provide adequate overview of the nursing provided at the home.

Systems were reviewed but this did not always lead to improvements. For example, regular medicine audits were undertaken and medicines were regularly discussed at meetings in order to improve the way they were managed. However, medicines were still not being managed in a safe way. A nurse manager, from within the organisation regularly visited Chollacott House to review the care plans, but had not identified the shortfalls in information.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Requires Improvement

Is the service well-led?

Generally staff felt the home was well organised and well led. Their comments included, “I think it is, but nothing is perfect”; “To an extent (the registered manager) does a brilliant job”, “(The registered manager is very up and running“, “(The registered manager) is very approachable, very organised” and “If you have a problem (the registered manager) will sort it.” The registered manager described how staff practice was monitored and addressed. An example was a three way meeting and additional supervision, where it was felt a staff was not meeting their obligations. Without exception staff praised the work of the deputy manager one saying, “Excellent. She never forgets anything.”

Staff were enthusiastic about the home and their work, one saying, “Good team work, support and training.” Staff felt it was good they were given the opportunity to think of improvements and feed this information back. Nursing staff described the monthly meetings where information was shared, one saying “We put our heads together and come up with solutions”. Care staff mentioned the usefulness of their staff meetings. One staff gave the example of highlighting a lack of options for the tea time meal and how those options were increased since they raised it.

The home was supported by the provider organisation that were available “24/7”, for example, for employment advice. The registered manager said she felt supported and able to deliver the service she felt was necessary. She told us of their activities budget and how any equipment required was provided. A representative of the organisation did a monitoring visit every two months. They reported in the ‘Service Development Plan’ 2015, that during 2014 they had met with people using the service on 11 occasions, five of those occasions with family and friends. Examples of changes resulting from surveys had led to improvements, for example, a kitchen assistant to help tea time on Sundays.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **There was a lack of effective systems to assess and monitor the quality of the service provided and identify, assess and manage risks relating to the health, welfare and safety of people.** **Regulation 10 (1) (a) (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Proper steps had not been taken through the assessment, planning and delivery of care to meet people's needs and ensure their safety and welfare.** **Regulation 9 (1) (a (b) (i) (ii)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **There were not appropriate arrangements in place for safe management and administration of medicines.** **Regulation 13**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Appropriate steps had not been taken to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced staff to safeguard the health, safety and welfare of people using the service. Regulation 22
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People were not protected against the risk of unsafe or inappropriate care and treatment because accurate records and appropriate information and documents were not always available and complete. Regulation 20 (1) (a)