Chadderton Total-Care Unit Limited

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Inspection report

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Date of inspection visit:
10 October 2017
11 October 2017
12 October 2017
15 October 2017

Date of publication:
23 February 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Chadderton Total Care on 10, 11, 12 and 16 October 2017. Our visit on 10 October was unannounced.

The service was last inspected in September 2015 and rated Requires Improvement. We identified seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to poor care planning and recordkeeping; inappropriately stored food; poor use of equipment and concerns around governance and supervision. Following the inspection the provider sent us an action plan which stated the breaches would be addressed. At this inspection we found significant improvements in these areas but we found a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014, relating to person centred care. You can see what action we told the provider to take at the back of the full version of the report.

Chadderton Total Care Limited is situated in a residential area approximately two miles from Oldham town centre. The home is registered to provide accommodation for 151 adults who require nursing or personal care. At the time of our inspection there were 136 people living in the home. It is a purpose built home, providing accommodation and facilities all at ground floor level. The service provides care for people with a variety of social and nursing needs including physical and learning disability, dementia related disease, and acquired brain injury. Many of the people supported at Chadderton Total Care had multiple and complex needs. The service is separated into five units. The Dales Suite is designed to care for people who have been assessed as needing residential dementia care. The Middlewood Suite is a small unit that cares for people with a variety of nursing needs. The Saddleworth Suite is a purpose built Dementia unit, which has recently undergone some redesign and modernisation to provide a more dementia friendly environment. The Young Disabled Suite provides care for adults aged 18 to 65 years old, and the Lakeland Suite is separated into three much smaller units named, Borrowdale, Ullswater, and Windermere, which provide care for people who have nursing needs.

A Registered Manager was in post. 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.

People told us that they felt safe at Chadderton Total Care, and when we spoke with staff they demonstrated a good understanding of how to prevent abuse. We saw that the service had safeguarding procedures in line with legislation and local authority policies so when allegations of potential abuse were raised these were reported and appropriate action taken to protect people from harm.

Staff were well trained and the service made appropriate checks during the recruitment process to ensure that new staff had the right attributes and character to work with vulnerable people. All new staff received a full induction, and systems were in place to provide supervision for staff. The service recognised staff

achievements and provided them with opportunities to develop their skills. We saw that there were generally enough staff on duty, but care workers informed us that staff would occasionally call in sick at the last minute and their shift would not be covered, leaving units short of staff.

When we looked at care plans we saw that potential risks to people's safety were assessed and measures put into place to minimise the risk, although in some the level of risk was not always clear. Environmental risks were also monitored; wide corridors and walkways allowed easy access, free from obstacles, and regular checks were made to ensure the building and equipment was well maintained. When accidents occurred the cause was analysed with steps to prevent further injury.

Since our last inspection the service had introduced a new system to manage medicines, which reduced the risk of errors, and allowed for a competent system to order, store and administer any medicines as prescribed.

The staff we spoke with demonstrated a good understanding of consent and choice, and there was some evidence to show they would advocate on behalf of people who used the service to ensure that their needs and wishes were met. However, where people lacked capacity there was sometimes an overreliance on the views of relatives for information which could lessen the person's independence.

The service had developed good relationships with health professionals such as general practitioners (GPs), opticians, dentists and dieticians to ensure health needs were met, and food and dietary requirements were considered. The service had recently employed a new catering manager who was reviewing the menus and food quality to ensure that people's preferences were taken into account.

Staff spoke fondly about the people who used the service and when supporting them with tasks they showed positive regard. However, we saw that staff were not always vigilant to people's needs.

Care files contained detailed information about people's needs,. Daily reports cross referenced care plans, but we saw that information was presented in a way which focussed on required tasks rather than the individual and how they would like their support to be given.

Throughout our inspection we saw a range of activities were offered, and activity coordinators showed a good understanding of what people enjoyed doing.

The service was managed by experienced people who showed a good understanding of how to meet people's needs and preferences. When we spoke with staff they told us they felt well supported and valued by their managers. Where people had cause to make complaints we saw that these were appropriately investigated and action taken to improve service delivery. We saw the service also ensured regular audits around the quality of the service were undertaken and the home owner had invested to review and develop the service to meet the changing needs of the population.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People who used the service told us they felt safe. Risks to people's safety and welfare were recognised and addressed.

Staff were recruited safely and there were sufficient well-trained staff to meet the needs of people who used the service.

A safe system of medicine management was in place.

Is the service effective?

Good

The service was effective.

Staff received regular supervision and appraisal.

Staff showed an understanding of capacity and consent issues. Where people were being deprived of their liberty the service had taken the necessary action to ensure that people's rights were considered and protected and the service was working within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

The environment was clean, light and spacious. Adaptations had been made to help make the environment more 'dementia friendly'.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were not always vigilant to people's needs.

Staff spoke kindly about the people they cared for.

People's belongings were treated with respect and personal information about them was stored securely.

Is the service responsive?

Good

The service was responsive.

The service had a range of activities and considered what activities people would like.

Care plans were up to date and contained sufficient information to guide staff.

The service monitored and responded to complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were systems in place to monitor the quality of service delivery but these did not address the vigilance of staff to people who use the service.

The service was committed to making improvements and had invested in improving service to people who are living with dementia.

Staff were supported and felt valued by the service.

Chadderton Total Care Unit Limited

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 10, 11, 12 and 16 October 2017 and was unannounced on the first day. The inspection team consisted of two adult social care inspectors, and two experts-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service, specifically working with older people and people living with dementia.

Prior to the inspection we looked at information we had about the service in the form of notifications, safeguarding concerns and whistle blowing information. We also received a provider information return (PIR) from the provider. This form asks the provider to give us some key information about what the service does well and any improvements they plan to make.

Before our inspection we contacted Oldham local authority commissioning team and the Clinical Commissioning Group (CCG) to find out their experience of the service. We contacted the local Healthwatch to see if they had any information about the service. Healthwatch England is the national consumer champion in health and care. We also contacted the local safeguarding team. This was to gain their views on the care delivered by the service. We did not receive any negative comments about the service.

During the inspection we spoke with the registered manager, the home owner, two unit managers, two nurses, eight care staff, two activity therapists, the catering manager and the maintenance officer. We spoke with fourteen people who used the service, seven relatives, a service consultant and two professional visitors.

We looked around the building, including all of the communal areas, toilets, bathrooms, the kitchen, and the garden. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us to understand the experience of people who cannot talk with us. We observed how staff cared for and supported people, and looked at food provision.

We reviewed the care records for eleven people, and eleven staff personnel files, and other documents related to the management of the home, such as maintenance records and service invoices.

Good

Is the service safe?

Our findings

When we asked, people who used the service told us that they felt safe. One person we spoke with told us, "Everyone is very nice; they help you when they are doing personal care and you feel safe when they are lifting you, and they always wear gloves and aprons. Yes, I know I am in good hands." Another said, "I feel safe because the people around me make me feel safe. My carers know all about my condition and how to help me, the staff are kind and respectful and they know me well, I feel safe when they are lifting me." A visiting relative informed us, "Yes, [my relative] is well looked after both in and out of her room and at night, she has a buzzer and a sensory mat."

Some of the people who lived at Chadderton Total Care were unable to give their verbal opinion about the care and support they received due to illness such as dementia and other sensory issues which made communication difficult. During our inspection we saw that staff took care to ensure people's safety and welfare. For example, when transferring people using mechanical equipment such as hoists, they were careful to ensure they explained each step, watched, and were mindful of the person's dignity treating them with courtesy and respect. At the last inspection we noticed that some people were using wheelchairs without footplates, which could cause injury to people's feet and legs. At this inspection we saw that some people chose to mobilise independently in their wheelchair by walking the chair with one or both feet, and this was reflected in their care plan. Where people were unable to do this we saw staff ensured that footplates were attached when mobilising people in wheelchairs.

All staff had access to the agency's Safeguarding Adults policy which provided guidance to the staff on their responsibilities to protect people from harm. Staff told us that they were aware of these procedures and understood how to safeguard people from different types of potential abuse. Staff we spoke to said they had received training about protecting vulnerable adults from abuse and discussed with us the signs that would alert them to potential abuse and the actions they would take. For example, we saw that where a safeguarding concern had been raised recently, the alleged incident was reported to the local authority safeguarding team who asked the service to conduct an internal investigation and report their findings. The safeguarding team were satisfied that a full and open investigation was conducted, and although the allegation was not substantiated the conclusion of the investigation recommended continued monitoring of the person and a review of the service whistleblowing policy. Both were carried out. This helped to protect not only the individual concerned but helped to minimise the risk of a similar event reoccurring to anyone else.

Staff were also aware of the provider's whistleblowing policy, and that this had been reviewed. When asked about this, one care worker told us, "If I was to see anything which put people at risk I would go straight to the manager. No hesitation!" Another told us, "I'd go straight to [the registered manager] or senior if she wasn't on duty. I trust her; she is fair and non-judgemental." A whistleblowing policy helps to protect people from improper or poor service delivery, and encourages the informant to report any improper behaviour. We also saw that the noticeboard by the main entrance included details of advocacy schemes in the local area. An advocate is a person who can represent a person who may not be able to communicate their needs and wishes, and act to ensure they receive a safe and effective service.

We saw that there was a good ratio of staff to people who used the service. The registered manager informed us that they used a dependency tool to determine how many staff would be required on each unit; each individual person was assessed for staffing dependency and staff rotas were based on people's individual needs. There was always a minimum of one nurse on the nursing and dementia units, and a senior carer and three care staff on all units. When people called in sick, agency staff were used, but carers informed us that if someone called in sick at short notice, there shift might not be covered. This meant that they had to work harder to meet people's needs. One person who used the service told us, "they have a lot of agency staff but they knew all about my condition." He told us the service tried to get the same agency staff to ensure that they were familiar with people's needs.

When we asked people who used the service, they felt that there were enough staff. One told us, "There is always someone there to help you, when you need it." Although others believed there were enough staff, they added that the response from staff to calls for assistance was not always prompt. For instance, one person told us, "When I need them they are not always there quickly, as there are such a lot of people."

We looked at the recruitment procedures, which gave clear guidance on how staff were to be properly and safely recruited. This helped to protect the safety of people living at Chadderton Total care. We looked at eleven staff files. These contained proof of identity, an application form that documented a full employment history and accounts for any gaps in employment, interview notes, a job description, references and eligibility to work in the United Kingdom. Checks were carried out with the Disclosure and Barring Service (DBS) before any member of staff began work, and copies were kept on the personnel files. The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. This meant that checks had been completed to reduce the risk of unsuitable staffing being employed at Chadderton Total Care. When nurses were employed the service checked with the Nursing and Midwifery Council (NMC) that the person was registered with them to provide nursing care.

When we toured the building we saw it was safe. Health and safety meetings were held quarterly with all department leads, including the kitchen and maintenance manager. Health and safety files on each unit contained information relating to the health and safety policy, and fire safety policy. Wide walkways were clear of any obstacles or trip hazards, and furniture was arranged to ensure easy access. When people were being helped with transferring into and out of chairs, staff were careful to avoid any bumps or bruises. Hazardous items, such as cleaning substances or flammable materials were stored safely in lockable cupboards, and notices displayed when doors needed to be kept locked.

We saw records indicated monthly checks were made and when servicing was required for the call system, lift, fire extinguishers and alarms and boiler and gas cookers; and when full checks were needed for water temperatures and legionella testing. Other equipment used to support care staff with people's personal care, such as hoists, and profiling beds had been serviced to ensure safe operation. The service employed three maintenance officers, who would check and action any routine repairs and checks. Larger repairs and structural requirements were contracted to the appropriate agencies.

The service kept a log of all accidents and incidents. We saw that details of any accidents or incidents occurred were recorded in detail, for instance, reports indicated the time of day the incident occurred, and change in environment and, where a fall or trip was noted, the type of footwear the person was wearing. Further analysis contained a breakdown by unit, number in the month, and the time of day incident occurred and falls in the month, date, unit and person. We noted a significant number of falls occurred on Saddleworth unit. This unit had recently undergone a full structural redesign and refurbishment to make it more dementia friendly and the registered manager told us that the improved environment had helped to

reduce the number of falls and trips on this unit.

At our last inspection we found that the service was not managing people's medicines safely. Since then, Chadderton Total Care have invested in new technology and now use a 'well pad' to manage the ordering and administration of any medicines required for people who use the service. This system asks named nurses to log in to a central record using their secure password and showed what and when medicines were required. A colour code indicated which medicines were due, if they had been administered or if they had not been given. This system reduced the risk of any medicine errors. The system was managed by the pharmacy, which could control any stock and deliver new medicines as required on a monthly cycle. When we spoke with nurses who administered medicines using this system, they told us that, it had "Taken some getting used to." They told us the main drawback was that any medicines prescribed out of the normal cycle or when new people were admitted into the service, the details had to be entered manually. However, they believed this was offset by the advantages; they found it a much more efficient system to manage people's medicines, as the colour codes would reduce the risk of error, and alert them should they miss someone's tablets.

We saw staff supported people to take their medicines and provided them with a drink to ensure they were comfortable in taking their medicines. The staff member remained with each person to ensure they had swallowed their medicines.

When we asked people who used the service, they told us, "the staff look after my tablets, and give them to me with a glass of water. They never forget and check they've given me the right ones." The system also noted any unused medicines and sent a reminder to return any unused medicines to the pharmacy for destruction, thus reducing the risk of overstocking medicines.

Each unit had a secure treatment room which was locked when not in use. All medicines were kept in medicine trolleys which when not in use were chained to the wall in the treatment room. Room and refrigerator temperatures were checked daily and a record was kept in order to ensure medicines were stored at the correct temperature. If medicines are stored at the wrong temperature they can lose their potency and become ineffective.

Controlled drugs are medicines named under The Misuse of Drugs legislation. The Misuse of Drugs Regulations 2001 and 2006 restricts how such medicines are stored and recorded. The home used some of these prescribed medicines and we saw they were stored in a further locked cabinet, and the controlled drug register was countersigned when administered. We checked the balance of controlled drugs for four people and found them to be correct.

We looked at eleven care records which showed that risks to people's health and well-being had been identified. These involved risks such as mobility, eating and drinking, nutrition and hydration, communication and hygiene. We saw that where a risk had been identified a corresponding care plan was put into place to help reduce or eliminate the identified risks. However, we noticed that the information recorded in risk assessments did not always indicate the level of risk, so it was unclear if the action required was proportionate to the risk. This meant that care staff following instruction in the care plans may overcompensate, and reduce the level of independence of the person using the service or undercompensate, which would increase the risk of harm. For example, for one person a risk of "poor" diet had been identified, but it was not clear if this reflected the person's appetite or requirements for specific types of nutrition. When we pointed this out to the registered manager they checked and updated the records. When we looked around the home we saw that steps had been taken to prevent injury or harm, for example, crash mats next to beds so if a person were to roll out of bed the risk of injury would be reduced,

and call bells were accessible to allow people who used the service to summon help.

We found systems were in place in the event of an emergency. There was a fire risk assessment in place and we saw that personal emergency evacuation plans (PEEPs) had been developed for the people who used the service. These plans explain how a person is to be evacuated from a building in the event of an emergency evacuation and take into consideration a person's individual mobility and support needs. The service also had a business continuity plan in place. The plan contained details of what needed to be done in the event of an emergency or incident occurring such as severe weather, fire or utility failures or mass staff sickness. Plans for the evacuation and re-location of the service in an emergency were also available.

Staff had undertaken infection prevention and control training, and those we spoke with understood the importance of infection control measures, such as the use of personal protective equipment such as tabards, vinyl gloves and other protective measures when handling food or completing personal care tasks and cleaning. Wearing such clothing protects staff and people using the service from the risk of cross infection during the delivery of care. Anti-bacterial hand gel dispensers were situated throughout the home. Posters detailing correct hand washing procedure were on display in all communal toilets and bathrooms and in the kitchen and laundry.

We inspected the kitchen and saw that it was clean and that the daily cleaning schedules were completed correctly. Food was stored safely and the fridge and freezer temperatures were monitored and recorded daily. These procedures helped to minimize the risk of food contamination. A 'Food Standards Agency' inspection had been carried out and the home had been awarded the highest rating.

Good

Is the service effective?

Our findings

People who used the service told us that they were supported by knowledgeable staff. One person told us the staff understood their needs and what was important to them. They went on to say if they felt unwell the staff listened and took action. A relative who was visiting a person who was unable to communicate their needs and wishes verbally told us, "Both [my relative] and me feel the staff understand his needs. What is important to [my relative] is that they can liaise and understand each other." When we spoke with people who used the service they told us the staff were well trained, and gave specific examples of how training had helped the staff to deliver good care. One person told us, "When they are showering me they have been trained, they have been on courses, they understand my needs and I understand them,", and another person, who was about to be helped to shower, said, "I feel I am in safe hands as they have all done training in lifting and handling."

The service employed a training officer, who ensured that all new staff were enrolled on the care certificate. This is a nationally recognised qualification for people working in the caring sector which provides the essential knowledge that any new care workers require to ensure they have the required competence to care for people safely and effectively. In addition, ongoing training was provided in a range of topics. We looked at a copy of the training spreadsheet which showed that people had received training in such subjects as moving and handling, first aid, food hygiene and health and safety. The record showed that further training had been undertaken by some of the staff in clinical topics such as diabetes management, nutrition, dementia care and end of life care. Group supervision would often be arranged to cover specific topics, such as foot care, to be delivered to all staff on a unit to ensure a consistent and knowledgeable approach. We were shown records of additional training for all nursing staff covering areas such as catheter care, medication and gastro feed accreditation, supporting them to maintain their nursing registration. A visiting relative commented, "I believe the staff are trained well. They are always going off doing something!" When we spoke to staff, they agreed that they received opportunities to develop their skills. One person told us, "Training is good. There is a training officer, who listens to our ideas and arranges training." They went on to tell us that they had recently received training around end of life care. They explained what they had learnt and how they had benefited from this training, for instance, they had used information to pay greater heed to oral care for all the people they supported. They had also recently completed workshops in dignity and respect and refresher training around safeguarding adults from abuse.

We saw that there had recently been particular emphasis on dementia training for staff on the newly refurbished dementia unit. For example, the service had arranged for 'Dementia Bus Experience' training provided by an independent training company which has been endorsed by the Alzheimer's Society.

We saw from the staff personnel files we looked at that when they first started at the home they received a full induction. Staff told us that that their first week was spent getting to know the service; they would complete initial mandatory training and tour the building, spending some time on each unit getting to know the people who used the service. They were then given a minimum of three months' probation, during which time their performance was monitored. This probationary period could be extended should the need arise.

The service had a supervision policy which stated that all staff would receive regular supervision from their manager. We looked at eleven personnel files which recorded when a formal supervision had taken place, and showed that all staff had an annual appraisal. However, we noticed that some scheduled supervision sessions had been missed and not rearranged. When we raised this with the registered manager she agreed to review supervision schedules and ensure that any missed supervisions were rescheduled. Supervision meetings enable managers to formally feedback and record performance and allow staff opportunity to speak in private about their training and support needs as well as being able to discuss any issues in relation to their work. The supervision records we reviewed showed that meetings were productive and staff used the opportunity to discuss issues of concern. At the last inspection we found that kitchen staff were not receiving regular supervision and that nursing staff did not have clinical supervision. Following that inspection the registered manager has ensured that all nursing staff now have regular clinical supervision and are supported to maintain and update their clinical knowledge. Senior kitchen staff have received instruction in the supervision process and all none care staff now receive documented supervision from their line managers.

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.

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 Deprivation of Liberty Safeguards (DoLS). By law, the Care Quality Commission must monitor the operation of any deprivations and report on what we find.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. At our last inspection we found that five people were being deprived of their liberty unlawfully. Following that inspection the service applied to the local authority for the correct authorisation and at this inspection the registered manager told us and we saw information to show that 54 applications to deprive people of their liberty had been authorised by the supervisory body (local authority) and we had been notified of these authorisations. A further four were awaiting authorisation. Where a DoLS had been requested or authorised the information was stored within the person's care records, along with details of why the DoLS had been agreed and any conditions relating to the restriction. We saw that the registered manager kept an updated list to show when a request had been made, authorised or was due to expire. This reduced the risk that the authorisation could expire without the knowledge of the registered manager and allowed a quick check to determine if the deprivation made was legally permissible.

The care staff we spoke with were able to demonstrate a good understanding of capacity and consent issues to help ensure that people's rights were protected, including pathways to reach best interest decisions. They were able to explain DoLS and mental capacity in terms of assessment and decision-making. Staff described to us how they gave people everyday choices, such as what to wear, what food to eat and what help they required with personal care. When we asked people who used the service they agreed that they were given choices, for example, one person said, "I please myself when I get up and go to bed," and another person told us, "I tell them what I want, and I come and go as I please."

We asked staff how they seek consent from people who were unable to state their wishes. They told us, "Even if they can't articulate I try to understand body language. Just because they can't speak doesn't mean they can't hear, so it's important to communicate. We offer choice and look for a response." They told us that sometimes they relied on families and relatives for advice about people's preferences. This meant that

there was sometimes an overreliance on the views of relatives for information which could lessen the person's independence or opportunities, as their views might be in conflict with the person's needs. For instance, where a family insisted that their relative sit in a specific area they were missing other forms of social stimulation and interaction. People who did not have family or representatives and were unable to speak for themselves had access to advocates who gave independent advice and acted in the person's best interest. Where this was the case, information about contacting the advocate was marked in care records to ensure they were consulted before any decisions were made.

When we looked at care records we saw these contained an eating and drinking care plan which made reference to any specific diet or need to prepare food in a specific way, such as pureed or mashable to aid digestion. The kitchen displayed information about specific dietary needs and staff understood the specific requirements of people living at Chadderton Total Care. All the people who used the service were weighed on a regular basis, and if there were any concerns, for example if the person was rapidly gaining or losing weight, a referral was made to the person's GP. Where dieticians or Speech and Language therapists had recommended specific diets to aid nutrition or avoid swallowing issues, care notes and records showed instructions were followed and one care file we looked at gave useful information on how and why a person needed to be supported with eating and drinking.

When we asked people about the quality of the food they were generally satisfied. One person told us, "[The] food is nice and tasty. I get enough," and another person said, "I have choices of food. I like Sunday's, its buffet day!" Other people we spoke with did not feel they have received good food, for instance, we were told by one person who used the service, "There's no taste. It can be the same day in day out." Whilst other people who used the service complained that their preferences were not taken into account. The registered manager was aware of people's dissatisfaction regarding the food provided, and had recently appointed a new catering manager to improve the quality. When we spoke to this person, they told us that they were keen to take on board people's preferences, and had consulted them to review and plan a two weekly menu. He was keen to ensure that meals not only tasted good, but were presented in a way which looked appetising, for instance, by using colour on plates and moulds for pureed meals. One person who used the service told us they were pleased that the new chef had come to talk to them to see what they would like to eat.

People had good access to healthcare and staff monitored their physical and mental health needs. One person who used the service told us, "I can always see my doctor when I need to, but I'm lucky as I don't need to take any medication." Evidence in the case notes we reviewed showed liaison with speech and language therapists, regular health checks and GP visits. We saw in care plans that people had regular access to other treatment such as dentist, optician and chiropody appointments. We saw evidence in care files and case notes of referrals, for example to mental health liaison officers, with records of advice taken and implemented by care staff. Where specific needs, such as eye care or concerns about pressure care were identified specific care plans were drawn up to meet any needs identified. This meant that people were receiving care and support to access additional health care services to meet their specific health needs.

When we last inspected Chadderton Total Care we noticed that some furniture and fittings such as carpets and curtains were worn. At this inspection we saw that improvements had been made. The service had sought expert advice to initiate a total refurbishment of the Saddleworth Unit to make it more dementia friendly, including structural alterations to allow more natural light into the building and unfettered access to an enclosed garden designed to be dementia friendly. Wallpaper had been chosen to prompt reminiscence and the staff were in the process of consulting people who used the service about the type and style of pictures they would like in communal areas and corridors. Doors of bedrooms had a façade to look like front doors, and people's photos were outside on their doors. There was signage to help people

living with dementia orientate themselves, for example signage for toilets and bathrooms. We also saw that some doorways, for example on the Young Disabled Unit, had been widened to allow easier access to toilets bathrooms and bedrooms.

Requires Improvement

Is the service caring?

Our findings

Staff spoke fondly about the people who used the service and when supporting them with tasks they showed positive regard. When we spoke with them they demonstrated a sound understanding of the people they supported, their backgrounds, values and beliefs, and we saw people were in general supported in a way they preferred.

When we spoke with people who used the service and their relatives some of the responses were complimentary. For example, one person told us, "The staff are very kind. They help me to wash myself and they talk to me and take an interest in me," and another remarked, "They are patient and kind, they understand me. When I say I am sorry for being a nuisance they tell me not to be silly, that's what they are there for." A visiting relative told us, "When I come all I can say is they are kind to [my relative]. They treat her with dignity and respect I see that. And others, when I'm here." Another visitor commented, "Staff are caring and they always go the extra mile, they don't get paid much but they are the backbone of the organisation. Nothing is too much trouble for them. They are very, very friendly," and a third visitor told us, "[The staff] are so gentle when they turn him, even when they don't know I am watching them."

Other people we spoke with told us that the staff were not always kind and caring, for example, one person told us, "Some staff knock on my door but some don't bother and that really matters to me," another person said, "When they are helping me with personal care, when going to the toilet, sometimes they wouldn't give me enough time to empty my bowels as it takes me a long time." The person went on to describe how this impacted on them in a negative way.

We saw that staff were not always vigilant to people's needs, for example, we saw one person had a huge stain down their jumper. This stain was dry and looked like the person had spilt a drink down themselves, which had not been wiped. We also saw some people had dirt trapped under their fingernails, showing poor attention to personal hygiene. On the second day of our inspection we noticed a person sitting in a chair on castors, watching the comings and goings on their unit. Two carers approached this person from behind without checking first that she was ready to be moved, asking permission or attracting her attention in any way. They pulled the chair back and wheeled her towards her bedroom without any communication whatsoever. When we observed the Saddleworth Unit we saw that a number of people living with dementia and having complex needs had been left to watch a DVD in an area of the unit was partitioned away from the main communal areas, and they were not being supervised. After the film finished the screen froze on a caption and these people were left unattended. One person began to get frustrated and began swearing, another began muttering and a third tried to take the blanket off the person next to them. They were left unsupervised for over ten minutes. Although no visible harm occurred, people were clearly frustrated and lacked positive stimulation during this period.

The above examples are a breach of regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; person centred care.

Whilst care staff were not always vigilant to people's needs, we saw some examples where they were. For

instance we observe a nurse passed by a person who used the service, as she passed she noticed the person and asked if she was alright, offering to fetch a blanket to keep her warm, and if she would like a drink. We also saw that, during a music therapy session on the Saddleworth Unit one person was becoming anxious. A care worker noticed and offered to take the person to a quieter place. She escorted the person to a different part of the building and sat with them making them more comfortable.

We also saw that people's belongings were treated with respect. We saw that where people were able, they could keep their rooms locked and kept their own keys.

We saw that when staff were attending to people's personal needs they ensured that curtains and doors were shut to allow privacy and minimise embarrassment. We observed staff offering people support with personal care in a dignified and discreet way.

We noted that all care records were securely held and maintained and only authorised staff had access to the information held about people who used the service; this helped to ensure that confidentiality was maintained. Care files contained a lot of information about what people's needs were. They began with charts to monitor interventions, such as toileting, pressure relief and dietary intake, and included risk assessments and care needs which were broken down into tasks. At the very end of this information was a document entitled "This is Me"; a life history that included the person's likes, dislikes, background and preferences which would help staff unfamiliar with the person to provide support in a person centred manner, The way files were laid out did not give a good impression of the person's character, as they slanted towards required tasks rather than an understanding of the person. We raised this with the registered manager, who agreed to review how information was compiled and stored.

The service supports people with a range of cultural and spiritual needs, and we saw that these needs were respected. Information about their background and beliefs was held in care records and any religious observations noted. A weekly Christian Church Service was held for people who use the service to attend if they wished. A Catholic priest also regularly visited the service. Religious dietary requirements were met, and where people had difficulty with spoken English the service employed carers who could communicate with the person in their first language.

When we looked at care files we saw each contained a section about care at the end of life. However, many of these remained empty, whilst others contained funeral plans or copies of DNAR forms. A DNAR form (do not attempt resuscitation) is a document issued and signed by a doctor, which advises medical teams not to attempt cardiopulmonary resuscitation. We saw from training records that many of the staff had been trained in providing good end of life care, but this was not reflected in the care files we reviewed which did not contain information about how people wanted to be supported as they approached death. We raised this with the registered manager who agreed to review the end of life care plans.

Good

Is the service responsive?

Our findings

People who used the service told us that staff responded positively to their needs, respected their wishes and promoted their independence, providing them with support when they required it. One person told us "I go to bed and get up when I want to but I always like to get up in time for breakfast." Another said, "The staff listen to me and respond to my needs. They chat to me, and make sure I get physiotherapy. I like doing the quizzes so there are things here for me to enjoy." Visitors agreed that the care and support offered reflected people's needs. One visiting professional said, "There are a lot of people with complex needs but they are on the right track, they know how to respond," and a visiting relative informed us, "[My relative has been here for a very long time, and has never had a bed sore, all her needs are met. Staff are always good with [my relative] and all her visitors, and know what [my relative wants]."

We saw that people did not have to wait unduly for support or care. We saw and heard staff responded quickly when alarm bells were called. We spent some time with a person who did not have any vocal communication, and was unable to use a call alarm due to mobility issues. This person spent most of the day in his room and was able to inform me non verbally that he was content; staff would regularly check on him and spend some time in his company. Throughout our inspection we noticed that staff would check as they passed the room, and acknowledge the person.

We looked at ten care records. These clearly documented people's needs and what support they required with day-to-day living tasks such as eating meals or with personal care. Where specific need was identified we saw that good instruction gave staff sufficient detail to meet the assessed need, and information of relevance to the individual was also noted in care files. For example, we saw in one file information to help staff understand "The active cycle of breathing" where a person had difficulty with this aspect of health. An accompanying note urged all staff to read this.

Records included good case recording by care staff and nursing notes, providing accurate and up to date information cross referenced to care plans and risk assessments. Specific Care plans were separated into thirteen sections to respond to specific needs of the individual. These were all kept up to date and reviewed on a regular basis; a monthly summary note indicated any changes needed in care plans. Care staff told us that the nursing staff would complete risk assessments but that they were involved in writing and reviewing care plans. They told us that they involved the individual in drawing up care plans. One told us, "We ask them what is important. Even if they can't articulate, we try to understand body language and check with them. Just because they can't speak doesn't mean they can't hear, so it's important to communicate and look for their response."

There was evidence of annual reviews where relatives and other interested parties were invited to consider any changes in need. When we spoke to people who used the service and their relatives they told us that they were involved in reviewing care plans. One person told us, "Yes, I am fully involved in planning my care, they always invite me and ask for comments," and a relative informed us that both she and her relative, "Sorted out and would review her care plan when needed."

Checks were made on weight, bathing records were maintained, and regular risk assessments were reviewed such as Waterlow pressure scores (which measures risk of skin breakage), or Malnutrition Universal Screening Tool (MUST) which is a commonly used screening tool which helps identify adults who are at risk of malnutrition or obesity.

When we toured the building we saw that dining rooms and lounges were homely and bright, so were inviting for people to sit in. In dining rooms, people could sit together around smaller tables, promoting social interaction. With the exception of the Saddleworth Unit there were no restrictions on people's movements within the building, and we saw a number of the people who used the service would spend time away from their units, sitting in other areas of the home and talking with other people and staff.

Care records for people documented their interests and what they enjoyed doing, and people told us that they were invited to participate in social activities. One person told us, "There is usually something going on, and we can chose to join in or not." Visitors told us about other activities which had been arranged, and one visitor told us, "When I arrived on the unit [my relative] was enjoying taking part in a word quiz and she enjoyed other activities such as scrabble and bingo." The home employed three activity therapists, so that people on all units could be given stimulation via a range of opportunities. Activities were quite wide-ranging, and during our inspection we observed a range of activities to provide stimulation to people who used the service, such as music therapy, film shows and karaoke.

We spoke with two activity therapists who demonstrated a good understanding and knowledge of people's likes and dislikes. By getting to know the person and their background they told us they can tailor activities people will be comfortable with. For example one pointed out a person who worked all his life as a carpenter. This person had a dementia related illness but was happily using wooden blocks to display his skills. The activity therapists told us that they are always trying to think of new activities and had recently bought a special revolving Scrabble game. At first this met with some resistance but now people on the Young Disabled unit "Are all hooked." A recent coffee morning in aid of MacMillan nurses was enjoyed by all attendees. We observed a word game which the majority of the people on the Young Disabled Unit and some other people who used the service joined in with very enthusiastically. The game was designed to be a little competitive to keep them mentally active. Both the activity therapists we spoke with demonstrated a real enthusiasm for their role and an eagerness to come up with new and interesting activities for the people who lived at Chadderton Total Care.

Whilst speaking with the activity therapist we also noticed that the home's Sensory therapist was massaging various individuals' feet, head, arms and shoulders and they certainly looked relaxed. The service also employs a physiotherapist and an alternative therapist.

Chadderton Total care had a complaints policy that was printed in the resident handbook and permanently on display in the main entrance where it was easily accessible. Blank complaints forms were also available. When we asked people who used the service they were able to tell us what they would do if they did have course to complain. One visiting relative said, "If there is anything I don't like I complain. I have made complaints and I feel I am listened to and my complaints are properly dealt with. I feel involved." They told us about a formal complaint they had made, and told us that they were satisfied, both with the outcome of the complaint and by the way it was handled by the service. People who used the service, when asked, told us that if they wanted to complain they would speak to either the registered manager or their unit manager. One said, "I have no complaints up to now but if I did have any I would go to the manager." All formal complaints were logged and numbered to allow for six monthly analysis. We saw that six complaints had been received in 2017. A complaints file included the original letter of complaint, summary, report of action taken, including any other agencies involved, the result of the investigation, review and any further action

required.

We saw evidence of regular consultation with people who used the service, and their views on service delivery were sought. A number of people told us that they had been asked to complete surveys about the quality and delivery of care and one told us that they had been approached by the new Catering Manager to find out what sort of food they liked. When they informed the catering manager that they were not happy with the food this person noted a subsequent improvement. We saw that the service had conducted a 'Resident satisfaction Survey in August 2017, but despite sending out a number of questionnaires they had relatively few back. However, the results were analysed and a report published with a copy on display on the main noticeboard. The results were mainly positive, with some negative comment about the standard of food. When we spoke to the registered manager she recognised that the survey method was not working and needed to find other ways to get feedback. She has now introduced a comments book at reception desk and placed a suggestion box in reception area.

Requires Improvement

Is the service well-led?

Our findings

It is a requirement under The Health and Social Care Act that the manager of a service like Chadderton Total Care is registered with the Care Quality Commission. When we visited the home had a registered manager who has been registered since March 2015. The registered manager was present throughout the inspection. Each unit had a Unit Manager and we saw that there was regular communication across the units, for instance we observed a unit manager meeting where issues around security, staff recruitment and deployment, safeguarding and capacity concerns were all discussed.

When we asked people who lived at Chadderton Total care they told us they believed the service was well managed. One person told us, "The home is well managed. I know who the managers are and I am not worried about approaching them with any worries or problems. I think it is a good home". Another, focusing his comments on a Unit Manager, described her as "the most caring Manager I have ever met."

When we asked the staff they felt they received the right support and training to manage their work. They told us, "We work together, care staff, nurses and managers. No one is unsupportive." When we asked their views of the service they were very positive. One person said, "I think it is brilliant. I would put a relative in here. There are a lot of good things going on." However, they stated that they would like more instruction at times, for instance, in how to deal with relatives.

We saw that staff co-operated with one another. Each unit was staffed by care workers, a senior care worker and at least one nurse in addition to the Unit Manager. All the staff we spoke with understood their role and function and where appropriate would follow up actions on behalf of each other. A regular visitor remarked of the staff, "I could never clean someone up like they do, they just get on with it." The service recognised staff achievements and awarded a monthly prize to 'the carer of the month' in recognition of good care.

We saw any communication with relatives was recorded in care files. The relatives of residents we spoke to told us that they were kept informed of any changes in their relative's condition and felt comfortable about contacting the service. One visiting relative told us that when they came to view the home they were given a booklet all about Chadderton Total care and offered a full tour around it. They were asked how and when they would like to be informed of any concerns regarding their relative, and told us, "I can walk out of here and I know I have done my best for my [relative]."

The home owner was supportive and made regular visits to the service. He had owned the service for over thirty years. In addition to providing general supervision and support to the registered manager he was familiar with and to the people who used the service. Staff told us he was approachable, would respond to any concerns and was prepared to provide staffing and equipment where necessary. For instance the catering manager told us he had been encouraged to seek resources, such as replacement fridges. New posts had been created to assist with the day to day administration of the service and to provide a range of therapies to enhance the well-being of people who used the service. When we spoke with the owner he told us he recognised that services such as Chadderton Total Care needed to reflect changes in the needs of vulnerable people, and was willing to invest to ensure that this service was able to adapt to meet those

changes. He had commissioned two independent inspections of the service to consider where improvements were required, and had employed consultants to help develop the Saddleworth Unit to reflect up to date knowledge, particularly around dementia care. He had invited leading experts to visit and comment on the plans to redevelop the service, and invested in training for all staff working on the dementia units. Both he and the registered manager were involved in local and national groups to ensure that the service kept abreast of best practice.

We saw that the service had systems in place to monitor the quality of the service to ensure people received safe and effective care. However, these systems had failed to notice the concerns we observed during our inspection, particularly as raised in the caring section of this report. The rating of Requires Improvement in this section of the report and the overall rating is reflective of this failure.

Regular audits and checks were undertaken on all aspects of the running of the service. The registered manager completed regular audits and provided a full yearly internal report for the provider. Reports covered staffing, training, resident issues, activities, nutrition, incidents, and medicines. Each unit manager and the registered manager would complete a monthly analysis of care records on random files and report on service delivery. This was used to analyse and look for any emerging trends or patterns.

We looked at an audit of accidents and falls. This provided evidence for trends and common factors and allowed for effective preventative measures to be put into place. Accident forms had been reviewed to include details of footwear, time of day of the incident and any changes in the environment.

The registered manager monitored cleaning schedules, weight charts, and food and fluid charts to ensure that these were completed in accordance with good practice guidelines. Where mistakes occurred these were addressed.

The service had a business continuity plan which covered essential areas to ensure the smooth running of the service in the event of a disruption, such as adverse weather conditions, fire or other emergency. This was reviewed by the registered manager in February 2017 with the next review due in February 2018. It covered essential areas of business continuity including staffing, food, medicines, utilities and equipment. Key contacts and responsibilities identified, but did not reference to how to manage if the electronic systems for medication recording failed.

We asked on one unit what would happen if the electronic medication system failed. The nurse on duty said they would revert to paper based medicines administration records (MAR) and showed us a documented process for doing so.

We looked at the business development plan. This showed an ongoing programme of refurbishment including regular painting, carpet renewal and upgrades for the Young Disabled Unit.

Staff had access to a range of policies and procedures to enable them to carry out their roles safely. The policies and procedures had been updated by the management team and cross referenced to new regulations. Copies of all policies and procedures were kept on all units.

The registered manager was aware of when notifications had to be sent to CQC. These notifications would tell us about any important events that had happened in the home. Notifications had been sent in to tell us about incidents that required a notification. We used this information to monitor the service and to check how any events had been handled. This demonstrated the registered manager understood their legal obligations.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Staff were not always vigilant to people's needs, and staff did not always seek permission to intervene.