Uniquehelp Limited

Chestfield House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 11 and 12 May 2016 and was unannounced.
Chestfield House provides nursing care and accommodation for up to 31 older people, some of whom may also be living with dementia. The service is an adapted detached building in Chestfield near Whitstable. The accommodation is provided on two floors, with bedrooms on both the ground floor and first floor, accessed by a lift and a staircase. There are three shared bedrooms and most bedrooms have ensuite bathrooms. On the day of the inspection, there were 28 people living in the service.

The service is run by a registered manager on behalf of the registered provider. 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.

At times insufficient staff were on duty to provide care safely. At other times, although people's personal care needs were met, there were insufficient staff available to interact with people so they received stimulation and emotional support.

People's care, treatment and support needs were assessed before they moved to the service and a plan of care developed. People's care and treatment needs were not always recorded in full to guide staff on how to effectively support people in an individualised way. Assessment of risks to people's safety and welfare had been carried out but lacked detailed guidance for staff to follow to ensure that safe practices were carried out. People were not always involved in care reviews and making decisions as their needs changed.

People were not fully protected by safe recruitment processes. The employment history of new staff was not explored thoroughly to ensure they were suitable to work with people.

Staff had completed some training to deliver care and support but this had not included all they needed to give them the skills or knowledge they needed to undertake their roles. Staff had regular supervision with a line manager to talk about training and development needs but staff appraisal requirements were not being met

The provider had quality assurance systems in place to ensure that care was given effectively, but where shortfalls had been identified, the action taken to address them was not always promptly completed. Policies and procedures were in place and in the process of being updated. Records were not all available for inspection.

Processes were in place to protect people from abuse. Staff understood how to protect people from the risk of harm and abuse. There was a safeguarding protocol in place that staff understood and said they would follow to help keep people safe.

Information had been gained about people's likes, dislikes and history. People were spending long periods without stimulating activities and staff were currently too busy to spend time with people. External entertainers visited and special occasions were celebrated such as people's birthdays. People were welcome to have guests to visit at any time, and to dine with them.

People had their health care, food and drink needs assessed and monitored and professional advice was sought as appropriate. People were offered choices at mealtimes, and where necessary support was provided to help people to eat and drink. People were not rushed and the dining room was welcoming so that dining was an experience to be enjoyed.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The appropriate assessments and DoLS applications had been made for people to ensure that people were not deprived of their liberty unnecessarily. All staff had received training in the Mental Capacity Act 2005 and understood how to apply the principles of the Act.

Medicines were stored safely and administered to people when they needed them by registered nurses, in accordance with their prescriptions, and with current legislation.

Staff received regular training to make sure they had the skills and knowledge to support people.

The premises were clean and signage throughout the service supported people living with dementia in their movement around the service. Staff checked that the environment was safe and that equipment was in good working order. Accidents and incidents were monitored and actions taken to ensure these were kept to a minimum, such as people being referred to the GP or to the falls clinic if they had fallen.

People, their relatives and staff felt confident to approach the registered manager or other senior staff if they wished to discuss a concern. The registered manager was a visible presence in the service and led an established staff team who were well regarded by people and their relatives. They listened to what people had to say and took action to address any issues they had.
The service had developed positive relationships with external healthcare professionals and people had access to care and treatment support when they needed it.

There were systems in place to ensure complaints and concerns were fully investigated. People had the opportunity to say what they thought about the service and the feedback gave the provider an opportunity for learning and improvement. Relatives said they would or had recommended the service to other people.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were not always enough staff on duty to meet people's needs.

The provider's recruitment procedures were not robust enough to ensure that suitable staff were caring for people.

Risks were not managed to ensure people were as safe as possible from harm.

Staff knew how to recognise and report potential abuse.

People received their medicines when they should. Systems were in place to ensure medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Systems to refresh training, support and appraise staff were not consistently applied.

People who lacked capacity were protected under the Mental Capacity Act 2005 and Deprivation of Liberty safeguards.

People were referred to the relevant health care professionals when required, which promoted their health and wellbeing.

People's dietary needs were supported and dining was an enjoyable experience.

Is the service caring?

Good

The service was caring.

People's privacy, dignity and independence was respected and promoted.

People were supported by staff that knew their needs, likes and preferences.

Advocates were involved if people needed them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some care plans had limited detail. There was a risk people would not receive care in a way that suited them.

Opportunities to take part in a range of activities were limited.

Relatives felt confident that any concerns they raised would be listened to and action would be taken.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider undertook audits to check the quality and safety of the service, but the improvements needed were not always identified within an action plan and monitored to ensure the service improved.

The registered manager supported staff to give good quality care.

People and their representatives were encouraged to share their opinion about the quality of the service.

Chestfield House

Detailed findings

Background to this inspection

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

This inspection took place on 11 and 12 May 2016, was unannounced and carried out by three inspectors and a specialist advisor. The specialist advisor had experience of dementia, older people, and the Mental Capacity Act and applying this experience to quality compliance in the care industry.

Before the inspection we looked at previous inspection reports and notifications. A notification is information about important events, which the provider is required to tell us about by law. We carried out the inspection sooner than we had planned so we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we looked at documentation about care including eight people's care plans, people's activity files, and a selection of medicines records. We referred to health and safety records, such as accident and incident forms, checks of equipment and utilities and personal emergency evacuation plans. We also checked two staff recruitment files, staffing rotas and appraisal, supervision and training records.

We spoke with eight people who lived at the service, six relatives and three other visitors who were familiar with the service. We observed how staff interacted with people. We spoke with the management team, seven care staff, and two ancillary staff. We 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.

The previous inspection was carried out on 5 September 2014 and this service was found to be compliant with regulations.

Requires Improvement

Is the service safe?

Our findings

People and relatives told us that the service was good, and that they had no complaints, but some thought there were not enough staff on duty. One person said, "Some staff have more time than others". One relative told us that, "Staff race around and get hot and bothered". We heard from another relative, "Staff don't have time to sit and talk; there's no interaction".

People's needs were not fully met by the numbers of staff on duty. A staff member told us there was enough staff "as long as everyone turned up". A relative told us that, "when there are unplanned absences the other staff have to work their backsides off". One person commented that at weekends there did not seem as many staff as during the week.

The registered manager had assessed each person's needs using a dependency tool and told us this was used to assess safe staffing levels. These dependency ratings for each person had not been used to ensure there were permanently enough staff to support people . The registered manager said that as there were 28 people living at the service there were more staff on duty in the mornings to give people the support they needed. There was always a nurse on duty, for both daytime and night-time.

We looked at the rota for the previous four weeks and found that there were occasions when the required staff levels had not been in place. Staff were supported by a cook, kitchen assistant, laundry person, two domestic staff and a full time maintenance person, however ancillary staff reduced most weekends, so that care staff then had to do other tasks as well as caring for people, such as preparing light meals and evening drinks in the kitchen. Staff told us that 23 people required two staff to support them with personal care, such as going to the toilet. If fewer staff were on duty and four staff at a time were caring for two people there was a risk that people had no staff member available to them in event of an emergency, or who could respond to them quickly in a service covering two floors of a building. A relative said to us, "I don't know if when (relative) can't get into bed help comes quickly or if call bells are answered but staff do pop their heads in the door".

During the inspection the required number of staff were on duty. However, we observed that people in the lounge areas and in their bedrooms spent long periods of time without much interaction from staff. People received a drink when the drinks trolley came round or they were assisted to the toilet and staff spoke to people while they supported them. One person in the service told us that, "if you hadn't come in it would have been half an hour before I saw anyone".

The provider failed to ensure sufficient staff were on duty to meet people's needs.
This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff sickness was covered by the registered manager and permanent staff and that they did not use agency staff. The registered manager told us there were currently no vacancies at the service, but new domestic staff had started work that week and a member of care staff was due to start next week.

The provider's recruitment processes were not robust.
Recruitment records did not show a full employment history in three of the staff files examined, which the regulations require to ensure safe recruitment practices were followed. However there were Disclosure and Barring Service (DBS) checks, (these checks identify if prospective staff had a criminal record or were barred from working with vulnerable people), proof of the person's identity and a recent photograph. The application form did not require staff to record dates of education or employment, therefore applicants had not always recorded the dates and this had not been checked during the recruitment process to question any gaps.

The provider had failed to ensure that all the required information in respect of a person employed was in place. This is a breach of Regulation 19 and Schedule 3 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's safety were identified, such as their risk of falling, of developing pressure ulcers or for people living with diabetes, having a fall or rise in blood glucose levels. For people with poor mobility a risk assessment was in place, which stated the number of staff and type of equipment they needed to remain safe. Guidance about action staff needed to take to protect people from harm lacked personalised detail that identified how people's individual needs could be met. Some care plans that described how staff would assist people to mobilise did not specify the exact type of equipment or the person's preferences regarding the activity. Some people either had, or could develop pressure ulcers and were nursed on air mattresses to relieve pressure to their skin and joints. Staff told us that visual checks were done to ensure that the air mattresses were working and any problems were reported verbally to the registered manager. There was no written protocol in place that ensured that this process was correctly monitored and reported by staff. There was no reliable mechanism to set, or check and record the pressures according to the person's weight, which was a key factor in the correct use of the mattresses to ensure pressure ulcers did not occur in people nursed constantly in bed. This placed people at potential risk of skin breakdown.

The provider has not done all that was reasonably practicable to mitigate risks to people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected from abuse and harm. Staff we spoke with were able to describe different types of abuse and knew how to report any suspicions or allegations within the organisation and to appropriate outside agencies. The provider had a safeguarding policy in place and the registered manager told us they had a copy of the local Kent and Medway safeguarding protocols to refer to. The registered manager knew how to raise concerns and deal with any allegations of abuse.

Regular checks were made of the environment to make sure that the service was safe and records showed all health and safety audits and safety certificates were up to date. Staff knew to report any accidents or incidents. Any person injured was referred to the appropriate outside agencies for treatment or assessment, such as the falls clinic. Faulty transfer equipment that was unsafe to use was withdrawn from use and replaced with new as soon as possible.
Fire equipment and current personal emergency evacuation plans (PEEPS) were in place for each person describing how to assist them to exit the building, along with the plan for where people were to be evacuated to. Cleaning products were locked away to prevent unauthorised access to them to reduce the risk to people being exposed to them.

Medicines were kept securely in a clean room. The temperature was checked twice daily to ensure the medicines quality was maintained. There was suitable storage for some medicines requiring secure storage and for those which required refrigeration. The medicines fridge temperatures were recorded twice daily.

Only trained nurses administered medicines to people. The medicines administration records (MAR) indicated that the procedure was followed safely and people received their medicines in the way they had been prescribed. Homely remedies (medicines bought 'over the counter') were available to people and were signed for individually by the GP to confirm they were safe to take with prescribed medicines. People who required these frequently were referred to the GP for a regular prescription.

One person was receiving a pain relief on an 'as needed' (PRN) basis and records showed this was being given according to the person's need and recorded on the MAR. A recent medicines audit had been carried out by the supplying pharmacy and documents illustrated how the registered manager was following the advice given because of this. When people received their medicines staff approached people explaining why they were there, put medicines on a spoon so it was easy for the person to get hold of, ensured the medicine had gone down safely and afterwards people had a drink to hand. One person had a liquid medicine and staff patiently put a very small amount on the spoon each time taking several times and followed this by giving the person a drink.

Staff received training in infection control and knew how to follow the infection control policy. Care staff had access to supplies of personal protective equipment, such as disposable gloves and aprons but did not wear always them. This is a practice that requires improvement.
Items for laundry were clearly marked and separated by personalised baskets to minimize clothing being mixed up. The infection control policy was clearly understood by laundry staff. We observed that the environment was clean and tidy. A team of domestic staff had a routine they followed daily throughout the service. Each day a different person had their room deep cleaned. This was carried out on a monthly basis for every room. The living and communal areas were free from odours and hazards.

Requires Improvement

Is the service effective?

Our findings

One person told us that if they wanted to see a doctor they "would only have to say". Relatives that we spoke with were happy with the care their loved ones received. One relative told us that they had no regrets about coming to the service because the "care is as best as can be expected". A healthcare professional told us there was a "good partnership" between them and the service.

Staff told us that new staff undertook an induction training programme that included shadowing experienced staff and familiarizing themselves with the building, procedures and people's routines. Care staff/nurses had access to training relevant to their role, but there were gaps in mandatory refresher training on the provider's training plan; such as safeguarding vulnerable adults, food hygiene, mental capacity and deprivation of liberty. Between six and 18 staff/nurses needed to undertake training in subjects where there was a shortfall to enable their practices and knowledge to be up to date in order to provide safe and effective care and support to people. There were also shortfalls in other training, which the provider classed as mandatory and additional training. For example, falls, death and dying, equality and diversity, diet and nutrition, challenging behaviour, communication and person centred care.

All staff had received training in moving and handling. However, we observed that some staff did not follow this training through into their practice and use the correct moving and handling procedures when moving or escorting people, to ensure people were safe. For example we observed one person being transferred from a wheelchair to a chair in the lounge and the person was distressed, crying out loudly. The equipment staff were using was not positioned correctly. The staff did not respond to the person's distress and carried on the transfer. The registered manager had to respond to the person's cries and calm the person down before the transfer was completed. However, at the end of the transfer the person was not positioned correctly in the chair and had to be positioned again. This was done using an inappropriate under-arm technique by the staff.

Staff did not always receive appropriate formal support. The provider's policy stated that care staff should receive supervision six times a year with a minimum of four completed. During supervision staff had an opportunity to discuss their learning and development and any concerns they may have. Records showed that nine care staff/nurses had only received one supervision during 2016, so there was some slippage on staff receiving regular supervision. The registered manager told us they intended to "catch up" during the month of May. The registered manager told us appraisals had been undertaken in 2015, but these records were not available as they had been archived, appraisals for this year were planned for June.

The provider had failed to ensure staff received appropriate training. This is a breach of Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

A rolling training programme for 2016 was in place and this showed opportunities for some of the identified gaps to be addressed. Nineteen care staff had a Diploma in Health and Social Care (formerly National Vocational Qualification (NVQ) level 2 or above. Diplomas are work based awards that are achieved through assessment and training. To achieve a Diploma, candidates must prove that they have the ability

(competence) to carry out their job to the required standard. The registered manager told us that the new Care Certificate was just being implemented in the service, and one staff member had undertaken their self-assessment. The Care Certificate was introduced in April 2015 by Skills for Care. These are an identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life.

Senior staff undertook some checking of competency of staff in practice such as medicine administration, moving and handling, communication, cleaning, laundry, personal care and wound dressing. Staff told us they felt well supported. There had been a staff meeting and a night staff meeting held during 2016. A member of staff told us that, "The staff get on here, no problems there".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Some people had a diagnosis of dementia or memory difficulties and their ability to make daily decisions and to be involved in their care could vary as a result. A person's capacity for making decisions was assessed by staff when they arrived at the service. Some of these assessments were now being reviewed to bring them up to date. Staff understood the MCA and allowed people to make decisions on their care and treatment on a daily basis.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Applications for DoLS had been made in respect of some people due to restrictions placed on them to keep them safe in their best interests, for example people who may be prevented from leaving the building on their own, or be subject to constant supervision. The principles behind the restrictions were described in the care plans, for example some people had been assessed as being deprived of their liberty due to being nursed in bed full time. Where possible family members had been involved in the decision making process to ensure the person's best interests were considered. People were asked to consent to the use of bedrails if these were needed for their safety while in bed.

People's preferences for eating and drinking were recorded in their care plans and passed to the catering staff so that they could provide the food and drink that people wanted. Advice was gained from the dietician or from the speech and language therapist when needed and the information shared with the cook so that people's dietary needs could be met. The catering team had a good understanding of people, their preferences, allergies and any special dietary requirements, such as food supplements or fluid thickeners. People who needed pureed food were given this in as attractive a way as possible. A risk assessment was completed by nurses for those people who were not eating or drinking adequately; to describe the support needed to manage risk. Staff assisted people to eat if they were unable to eat independently. We observed that staff were doing this in an unhurried way, protecting people's skin, clothing and bedclothes from spillages.

People were offered a daily choice between one main course and some lighter alternatives. The kitchen team had a clear and colourful pictorial guide to show to people who had difficulty in expressing their wishes, to support them to choose the food they wanted. If people were hungry between meals care staff obtained sandwiches for them.
People celebrated special occasions in the dining room or in their own rooms with relatives and friends and

staff made visitors welcome at these events. At lunchtime people used the dining room where there was plenty of chatting between people, and between people and staff while meals were served. Some of the visiting relatives were present to enjoy lunch with their loved ones. The tables were fully dressed and the room was pleasant to be in. People told us the food was good and that there was enough to eat.

Drinks of various kinds were offered during, after and between meals and we observed that people had a drink available to them throughout the day. Some people were reliant on staff to have drinks offered to them at regular intervals. We were informed that no one was at risk from inadequate fluid intake. Staff noted when people did not drink much and verbally passed this on to the registered manager, but there was no reliable record to show people were being offered or drinking adequate amounts of fluid for their wellbeing. When asked about this the registered manager told us that fluid charts would be put in place so that staff could ensure that people were having the recommended daily fluid intake, and that this process would be monitored. The fluid charts were in place by the second day of the inspection.

Care plans showed that nursing staff responded promptly to people's health needs when they changed. One person had developed leg ulcers and a new way of treating them was being tried out by the nurses. Information in people's care plans showed that referrals were made to the relevant healthcare professionals when necessary. One person said that there was 'access to a doctor if I want one'. Relatives told us that the staff contacted them promptly if there had been a change in their family member's needs and if medical intervention was required. One family member told us that they had been well supported by the registered manager and staff who had been "brilliant" and adapting to the increasing needs of their relative and working with the healthcare professional. We saw documented evidence of visits from the GP, dietician, audiologist and optician. A healthcare professional told us that the staff responded quickly to all their requests for tests to be done on people. There was a GP available each week, visiting people on different floor levels alternately, but available for consultation with any person if it was required. One person had requested to see a doctor who was not the one who was covering that floor that day – but that the person's choice had been respected and they had seen the doctor they wanted. The registered manager also accessed an NHS website for obtaining additional support from GPs if required.

The interior of the building was suitable for people's needs. Signs to show fire exits and to identify different rooms were clear, and to help people navigate the corridors people's rooms were clearly marked with their names and a photograph. People had their own possessions and furniture in their rooms to personalise them. The dining room was a bright and clean space, on the wall a large map of great Britain was utilised to show people where well remembered 'road trips' had been made. A large calendar and a weather chart of the day helped people orientate to the present day. As well as a garden there was an attractive rooftop garden for people to enjoy with support from staff to access it via the patio doors.

Good

Is the service caring?

Our findings

People told us they felt care staff understood their needs and said they received a good level of care and support. One person said, "It's lovely here, I am well looked after and I have no complaints at all. I can always call someone if I need any help". Another person said they had "always been happy here" and that "everybody is good to me".

People we spoke with could not recall being involved in the reviews of their care and treatment. Relatives told us that they had no complaints about care, but that they had not been involved in the development of their family members care plan nor attended reviews and gaps in documentation supported this. We have identified this area for improvement. In spite of this, the relatives felt the staff understood people's needs and they had been asked about their family member's preferences and that these had been supported. We were told how one person's medicines had been reviewed by a GP resulting in improved mobility for the person. A special chair had been purchased by the service for a person so they could sit out of bed instead of being nursed full time in bed. This was something that had not been possible before the person came to the service.

We observed patient, kind and caring interactions between people and staff. Some people had difficulty in communicating their feelings to staff, but staff showed they knew what the person might need. When staff could not respond to a person immediately, when answering a call bell they would reassure the person that they would not be long. Staff noticed when a person had been to the hairdresser and commented on how nice their hair looked, bringing a smile to their face. One person described how they were encouraged to personalise their room and how staff enjoyed talking about the curios they possessed, with them. One person's relative was assisted to tend to potted patio plants for their loved one to enjoy.

Visitors told us they were always made welcome and were able to visit at any time and also to take people out on trips. As well as visiting people in the individual units or bedrooms, there were other areas where visitors could spend time with their relatives and friends. One person met with their relative in a quiet lounge on a daily basis so that they could enjoy the view onto the roof garden and speak together without interruption from other people. This arrangement was facilitated by staff, who brought tea to the room for the couple to enjoy. A person told us, "It's lovely here, I am well looked after. I can always call someone if I need any help. I'm in a wheelchair so I don't go out , but I could if I wanted to".

At lunchtime two staff were on duty in the dining room, where 12 people chose to have their lunch. Staff were attentive, getting napkins, offering choices of drinks and getting refills when required. People were confident in asking for things they wanted, such as more napkins or different drinks. People were asked whether they wanted to wear a clothes protector and one person was offered a choice of the type as they had this across their lap. Three people were discussing the patio door being open; staff quickly noticed this and offered to close it. People requested a window was opened instead and this was done. Staff brought meals to each person and explained what was on their plate. Staff sat with some people and chatted whilst assisting them with their lunch. They continually checked if people were happy. One person replied the lunch was a bit warm and staff made sure they took the next spoonful from around the edge of the plate

where the food was cooler. Other people sat chatting to each other in a relaxed and sociable way.

The registered manager came into the dining room with some pictures of the flowers in the garden and proceeded to put them up on the patio doors, involving and talking to people on the nearest table about the flowers and gardening.

A healthcare professional and a visitor told us that in their experience, people were treated with dignity and respect, staff were caring towards people and each other, and they had found that staff strived to maintain people's independence. Other relatives told us that people's privacy and dignity was always respected. People were asked where they would like to sit for lunch. We observed staff transferring a person on a hoist in a communal area. To help maintain the person's dignity a screen was used to block the view of people nearby. One person told us that 'staff were 'respectful when they spoke to them and were not overbearing'. Another said that staff, "Talk to me nicely".

The registered manager told us they had recently registered to become a dignity champion. Dignity champions are part of a national scheme and a dignity champion is someone who believes passionately that being treated with dignity is a basic human right, not an optional extra. There is a ten-point challenge, which describes the values and actions quality services should adhere to that respect people's dignity and this was displayed at the service.

People who required them were provided with independent metal health advocates (IMCAs). IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person. We observed that an IMCA arrived during the inspection to see a person who needed support to make decisions.

Care plans for people at the end of their lives showed that the GP and staff supported pain free, comfortable and dignified death though no person was at this stage during our inspection. The families of people with 'Do not Resuscitate orders' in place (DNARs) were consulted about this to ensure it was in the persons best interests. Information about people was kept securely when it was not being used by staff.

Requires Improvement

Is the service responsive?

Our findings

People told us that they would have no hesitation in speaking to the manager if they wanted anything. Relatives told us they were asked "all the time" if there was anything they were worried about, or needed. They said that they felt comfortable going straight to the registered manager with any concerns they might have. They had confidence that support and information would be provided to them. One relative said, "The manager is very receptive". Another relative told us that the registered manager or staff always quickly addressed any concerns they had. One person's relative told us the service had done a, "Brilliant job for (X). They have always helped and supported".

Before people came to live at the service the registered manager, or in their absence a deputy, completed an initial assessment to determine whether the service had the skills and capacity to meet their needs. People then had a care plan drawn up for them outlining their needs.
However, care plans we checked were generic in nature and did not give the required detail to ensure that personalised care, to suit the individual's choices and preferences would be given. Care plans did not state for example, whether a person preferred a bath or a shower. One person was offered pain relief based on the staff being able to interpret facial expressions, but there was limited detail as to what facial expressions staff should expect or how to interpret the different expressions the person showed. Guidance for a person living with diabetes whose blood sugar levels were monitored, had insufficient detail to inform staff what to do in the event of a low or a high blood sugar result to ensure that the person received the correct treatment. Specific details about peoples' wishes, such as cremation or burial, and any special requirements at a funeral service were lacking in the care plans. This shortfall in gathering information meant that staff lacked information on how to address some care and treatment needs people had.

The provider was not carrying out collaboratively, with the relevant person, and assessment of the needs and preferences for care and treatment of the person. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A booklet called 'This is me' gave detailed information on peoples' lives, families and interests and daily records were kept about the activities people undertook. However recent entries included, 'X watched TV this morning' or 'X spent time in their room'. We observed people sitting in lounges and in their bedrooms without activity while staff were busy completing care tasks and too busy to talk much with them. One person told us, "Not much to do, someone comes to sing. I read books". The only entertainment during inspection was the television, although people appeared to be not really watching it. The registered manager told us staff were supposed to do activities with people, but observations showed that from after lunch until at least 4.30pm staff were very busy and they did not have the time to spend with people due to their other duties.
People were supported to go out of the service as much as they wished. One person told us that a wheelchair transporting taxi would be called for them if they needed it. Staff had provided no activities for some time. This was an area we discussed as needing improvement with the registered manager who told us they were in the process of employing a new activities coordinator who would work with people for 15 – 20 hours per week.

Staff rotated in teams throughout the service in order to get to know all the people they cared for and so people would know about people's needs, preferences and routines. Staff coming on shift received a handover from the nurse in charge in which people's progress was discussed. We observed how staff were told how to support people with their care and treatment needs, such as encouraging people to drink adequate fluids and about people who needed support in a different way because they were unwell, or had improved. Care and treatment for a new person to the service were described verbally in detail so that staff knew that the person would need two staff to assist them to walk or transfer using equipment, and about their other needs such skin care, special diet and medicines.

People's care needs had been reviewed regularly and signed by the registered manager to indicate whether there were any changes to the care plan or not, but there was no record of people being involved in the decision-making processes about their care and treatment, and there was inconsistent involvement of relatives. Some relatives confirmed this and two people told us that they could not recall a review of care being held with anyone. We discussed this with the registered manager who confirmed that people had not been fully involved with any reviews of care that had been completed and that this was an area in which practice needed to be improved. The registered manager did show us a document that recorded their personal discussions with people that they carried out on a regular basis. This discussion included asking people how they were, if they had any problems with their laundry , if they were satisfied with the activities, food, state of cleaning in the service etc. The manager then used people's responses to help them make improvements but a record of their actions was not kept.

People participated in residents meetings where they had the opportunity to voice their opinions about their care and support and raise any concerns they may have had. People that spent time in their rooms were also asked individually about any concerns or changes they wished to make. For example, people had requested menu changes and these had been implemented. We observed that the registered manager frequently spoke to people in the service and was able to react informally to their requests. In addition the registered manager regularly made time speak to people and record their views in relation to the food, activities, laundry and cleanliness of the service.

There was a complaints procedure displayed within the service, but this did not inform people of their right to take their complaint to the local government ombudsman if they were not satisfied. A new complaints procedure had been drafted to address this shortfall and the registered manager told us this was waiting for the provider's approval before being implemented. Relatives told us they did not have any concerns and felt comfortable in raising anything that might arise. The latest quality assurance surveys indicated people felt any complaints were dealt with satisfactorily. The registered manager told us there had been one complaint in the last 12 months. However, these records had been archived. They said the complaint had been in relation to an odour in a bathroom, action had been taken to address this and a written response had been sent to the complainant. Several compliments letters or cards had been received from relatives and these were held on file.

Requires Improvement

Is the service well-led?

Our findings

People and relatives felt the service was well led and well managed. One relative told us they were very happy with all the care and support provided and they would certainly recommend this service to others. One person told us, "The manager is very professional. They run a tight ship". However, we found aspects of the service were not well led and required improvement.

The registered manager was unable to produce some records required during the inspection. They told us staff appraisal records and a record of a complaint had been archived and therefore was not available to check. A number of records were incomplete and did not ensure that staff had the information they needed to ensure people received the appropriate care and support they needed.

Systems to assess monitor and improve the quality and safety of the service were not always effective in identifying and addressing shortfalls in a timely way. The business plan stated that an infection control and pressure sore audit would be undertaken. The registered manager told us although pressure sores were monitored closely, no monthly audit was in place. An infection control audit had not been undertaken during 2016.

Senior management visited twice during 2016 to undertake audits and produced a report. Some of the shortfalls identified during the inspection had been picked up through these audits, such as care plans were required to be more person centred, staff equality, diversity, and palliative care training, and shortfalls in activities. However, although senior management added comments to the action plan these were not effective in driving improvements. For example, the comments against training shortfalls were noted as 'on-going', but the training programme in place did not include any training for palliative care and the training for equality and diversity was not planned until December 2016. The action plan did not clearly state when and by whom the actions should be achieved.

The business plan stated that staff were trained in equality and diversity, but only 13 of the 39 staff on the training matrix had completed this training. It also stated staff had palliative care training and again only a few had completed this training.

The provider had failed to establish and operate effectively systems and processes to assess and monitor the quality of service people received. The provider had failed to ensure there were complete and accurate records of care and treatment for people. This is a breach of Regulation 17 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other audits were in place, such as monthly checks on whether the airflow mattresses were working, a monthly analysis of accidents and incidents and a care plan audit were undertaken.
The registered manager had notified the Care Quality Commission of all significant events which had occurred, in line with their legal responsibilities.

There was an open and can do attitude within the service, which focussed on people.

In the last quality assurance survey people and relatives indicated that management made them feel welcome and people we spoke with confirmed this. The statement of purpose and service user guide, complaints procedure and last inspection report were available in the service for people, visitors or staff to read.

Staff told us they had access to policies and procedures within the office. The registered manager confirmed that they did not check if staff kept up to date with the service policies and procedures.
A new set of policies and procedures had recently been introduced and a few had been printed off, such as the whistle-blowing policy and deprivation of liberty safeguarding policy, but the registered manager told us others remained on line as they were continually updated.

Staff said they understood their role and responsibilities and felt they were well supported and motivated by the registered manager. One staff member said, "(The registered manager) is a good manager, they listen and you can ask them anything". Staff had team meetings where they could raise any concerns. Staff surveys had been introduced this year and recently sent out. Most staff had been working at the service for a long time. One member of staff told us that staff "worked well as a team". They told us, "I like my job we chat and have banter with people".

The registered manager was supported by a deputy manager, who was also a nurse, and had worked at the service for some years. The deputy manager was undertaking an additional nursing degree and had previously completed a leadership and management qualification.

People had opportunities to provide feedback about the service provided. People or relatives had been given the opportunity to complete a quality assurance questionnaire in March 2016. The results had been analysed and the registered manager told us at the time these results were displayed for people to see. The results showed that overall people were satisfied with the care provided. Relatives we spoke with also told us that the provider regularly asked them about the care and support that was provided to their family member. This enabled the provider to monitor the service that was being provided.

One health professional and relative talked about the good partnership working and professionalism of the registered manager, who was a trained nurse and had worked at Chestfield House for over fifteen years. They usually worked Monday to Wednesday and on Fridays were acting as the second nurse when they were on duty. They were visible within the service to people and relatives who felt they were approachable and would swiftly sort out problems. The registered manager kept their professional skills updated by following online professional revalidation processes, through membership of recognised groups and forums and by linking with other local providers.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider was not carrying out collaboratively, with the relevant person, and assessment of the needs and preferences for care and treatment of the person

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to do all that is reasonably practicable to mitigate risks to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to establish and operate effectively systems and processes to assess and monitor the quality of service people received.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure that all the required information in respect of a person employed was in place.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider failed to deploy sufficient numbers of staff to meet people's care and treatment needs.

The provider had failed to ensure staff received appropriate training.