Barchester Healthcare Homes Limited

Chalfont Lodge

Inspection report

Denham Lane
Chalfont St Peter
Buckinghamshire
SL9 0QQ

Tel: 01753888002
Website: www.barchester.com

Date of inspection visit:
06 April 2017
07 April 2017

Date of publication:
09 June 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook an unannounced inspection of Chalfont Lodge on 6 and 7 April 2017.

Chalfont Lodge provides care and nursing for up to 119 people. The home is divided into five units over two floors. Three units are dementia care units, known as Memory Lane. Sunningdale unit provides general nursing care and Turnberry unit is for people with physical disabilities. During our inspection there were 99 people living at the service.

There was a registered manager 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.

Although some staff felt there were not sufficient staff we found staff rotas showed the number of staff were over complement of the required number as per the dependency tool. However it was accepted by the manager that staff deployment could be improved.

The service had safe recruitment procedures and conducted background checks to ensure staff were suitable to undertake their care role.

People and their families told us they felt safe at Chalfont Lodge.

On the day of inspection, staff understood their responsibilities in relation to safeguarding people. Staff received regular training to make sure they stayed up to date with recognising and reporting safety concerns. The service had systems in place to notify the authorities where concerns were identified. We had received information which showed staff's understanding on when to report incidents needed improvement. The manager and area manager were working with the staff to ensure responsibility of reporting was further embedded.

People benefitted from caring relationships with the staff. People and their relatives were sometimes involved in their care and people's independence was actively promoted. Relatives and staff told us people's dignity was promoted.

Where risks to people had been identified, risk assessments were in place and action had been taken to manage these risks but these were not always effective. Staff sought people's consent and involved them in their care where possible.

People and their families told us people had enough to eat and drink. People were given a choice of meals and their preferences were respected. Where people had specific nutritional needs, staff were aware of, and ensured these needs were met.

People told us they were confident they would be listened to and action would be taken if they raised a concern. The service had systems to assess the quality of the service provided, but these were not always effective to ensure people were protected against the risks of unsafe or inappropriate care.

We had mixed feedback from staff about the support they received from the manager and the deputy manager. Staff supervision and other meetings were scheduled as were annual appraisals. People, their relatives and staff told us all of the management team were approachable and there was a good level of communication within the service. However, meetings, for example staff meetings were not always frequent.

People and relatives told us the team at Chalfont Lodge were very friendly, responsive and overall well managed. The service sought people's views and opinions and were in the process of acting on this feedback.

We found one 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 this 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 always safe.

At times on the Sunningdale unit, staff were not always deployed effectively.

People received their medicine as prescribed.

People and their relatives told us people were safe. Staff knew how to identify potential abuse and raise concerns.

Risks to people were identified and risk assessments in place to manage the risks. Staff followed guidance relating to the management of risks.

Accident and incident analysis of falls needed improvement.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the training and knowledge to support them effectively.

The Mental Capacity Act (2005) principles were followed by the provider.

People were supported by staff who were supported, supervised and trained.

People had access to healthcare services and people's nutrition was well maintained.

Is the service caring?

Good

The service was caring.

People told us staff were caring.

Staff were kind, compassionate and respectful and treated people with dignity and respect which promoted their wellbeing.

Staff gave people the time to express their wishes and respected the decisions they made. We saw people's consent to care was obtained.

The provider and staff promoted people's independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were assessed prior to moving into Chalfont Lodge to ensure their needs could be met.

Care plans contained good information about people. However, supplementary care records were not maintained.

People were supported in their decision about how they wished to spend their day.

People and relatives knew how to raise concerns and were confident action would be taken.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service did not have effective systems in place to monitor the quality of service. People's records were not robust or complete.

People's views were sought on the quality of the service.

People, their families and staff told us there was mainly good management and leadership in the home.

Chalfont Lodge

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 6 and 7 April 2017 and was unannounced. The inspection was carried out by one inspector, a specialist advisor (SpA) and two Experts by Experience. An SpA is someone who has knowledge in the care of people in a nursing setting and older people's care. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the service. This included notifications about important events which the service is required to send us by law. We sought feedback from the commissioners of the service and other stakeholders.

We spoke with the local authority and their safeguarding team about a recent incident which had occurred. They provided us with information about the management of the safeguarding incident and details of the outcome.

During the inspection we spoke with 13 people who used the service, 14 relatives of people and three professionals.

We looked at ten people's care records, eight medicine administration records. This included, covert medicine records, PRN protocols, DNAR (Don not attempt resuscitation) records and ten specific monitoring charts of people. We also looked at four staff records and records relating to the general management of the service. We spoke with the registered manager, the deputy manager, the Regional Director for the home, twelve care staff, eight nurses, the chef and one of the activity co-ordinator.

We conducted a tour of the building with the manager to view the environment.

Requires Improvement

Is the service safe?

Our findings

At our comprehensive inspection on 31 March and 1 April 2016 we found there was not always enough staff deployed to meet people's needs. This was a breach of Regulation 18 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan telling us how there were going to make improvements. They told us they would continue to recruit both nurse and care staff and they also continue to review staffing numbers by using an objective, evidence based tool and meet the recommended guidelines. They also said the manager would monitor the staff to ensure appropriateness of experience, competence and skill mix is sufficient.

At this inspection we found improvements to staffing levels had been improved overall, but staff and people felt one unit, Sunningdale, would benefit from further review of staff numbers.

Risks to people had been identified on all the units. For example risks associated with the use of bedrails. Other risks were identified which included the use of airflow mattresses, falls and the development of pressure sores.

Staff on the Sunningdale unit told us they felt there were not enough staff to meet people's needs. They said that although they had fewer beds than the other unit Turnberry, on Sunningdale unit there was a higher dependency for people who required nursing care. We saw there were times when people who were in the small lounge were not regularly checked. We saw one person in this lounge that had little interaction from care staff. On one occasion, this person was left for 35 minutes on their own. We had concerns that people who could not reach their call bell and were required to have hourly checks, were not receiving these checks as records were incomplete. Other comments received from staff were "Staffing not too bad, but would benefit from more staff. I spoke to the manager as some people take more time to look after than the other units and this is not always picked up through the dependency tool. Mornings are busier as residents want to sometimes get up at the same time".

One relative told us how their son had needed assistance with personal care. They told us they approached a care staff member from another unit, they told them, they were unable to help as they were from a different unit. This meant this relative's son was left on the toilet and had to wait ten minutes before another staff member was available.

Some people told us they had to wait for assistance. For example, one person said that the week before our inspection, they had to wait 45 minutes before their call bell was answered. They said this was the second time since Christmas. They said this may have been an agency staff member and that they had raised concerns with the manager about this and the poor care from agency staff. People said, "Sometimes staff seem so rushed and tired, three of us (people) had a talk and we think we need to get extra members of staff up here and downstairs. We think this would make it better" and "Mostly there is good coverage and staff come quickly".

We saw at lunchtime on the Sunningdale unit staff were available to assist people with their meal, but were

not available in the dining area to motivate some of the residents who were confused. Some residents were unsure about their food and were not encouraged to eat. We discussed this with the manager and they confirmed they had seen that staff were not deployed as normal. They said this was not acceptable and would review the staff deployment, especially at lunchtime.

We saw other units at Chalfont Lodge were appropriately staffed. Staff told us on the Turnberry unit that staffing was usually fulfilled except on a few occasions when staff called in sick at last minute. One staff member told us "Staff used to be a problem, especially agency, but not now and we can cover internally which is good for continuity. There is enough staff now, but maybe the Turnberry unit would possibly benefit from an extra nurse on duty". Other comments included, "We don't rush, we make sure everyone is ok, we make sure we are not showing the resident we are rushed" and "Always work in double ups for people and there is enough staff to do this".

Two out of the three professionals we spoke with felt that there were enough staff to meet people's needs. Comments included "Enough staff, no issues"; "I have seen no problems at lunchtime"; However, one professional said on two occasions that the home, including, Sunningdale unit would benefit from improved clinical leadership. They said "The home does have its challenges due to the nature and needs of people who live there. They could do with a bit more clinical lead".

Assessments were done when people arrive at the home. They were rated as low, medium, high or very high. We saw the manager reviewed this on a weekly basis and updated the dependency tool to reflect any changes. Staff told us if any changes to people's needs were identified, they would inform the nurse on duty who would assess the person and change the care plan accordingly.

We looked at the dependency tool the manager used to calculate staffing numbers. We reviewed the staff rotas in March and beginning of April 2017. The rotas showed staff numbers were regularly met in the day for both nurses and care staff. On most days the staff rotas showed numbers were in excess of the recommended dependency tool. However, there was one unit, Memory Lane where there should be two nurses. The manager told us if this was not possible, then the number of care staff would be increased from three to four. There were five occasions when the service was one staff member short. However, we did not receive any complaints or concerns about the level of care provision at night.

People and their relatives told us they were safe. Comments included; "Yes I do. If I ring the bell I don't have to wait for assistance"; "I am safe in here and with the staff and carers" and "I feel very happy and safe here". Relatives told us, "Definitely, [name] is extremely well looked after by all staff"; "When I walk out of here, I have greatest peace of mind that [name] is well looked after"; "Yes, he is safe with most of them, some of the staff are really good" and "My husband feels safe and very happy although he had not been in the home for a very long time". Staff comments included "People are safe, I have no concerns. We take care of them very well"; "I have no concerns what so ever" and "People are well looked after and safe". Professional feedback included "People are safe, they are not at risk here" and "I am not worried at all, people are safe here".

People had equipment to enable them to move around the home safely and staff were aware of when this equipment should be used. We saw people were transferred safely, for example, from their wheel chair to a lounge chair by care staff. We saw evidence that equipment checks were carried out to ensure they were safe to use, for example, hoists. However, we saw one type of equipment, turntables where there was no sticker to indicate the equipment had been checked. This piece of equipment assists people with the help of staff to turn around before positioning them in a chair for example. We raised this with the deputy manager, they told us they would investigate this and ensure the equipment was checked.

We saw staff ensured wheelchair footplates were in place and that people were positioned correctly in the wheelchair. Where people were at risk of falling from the wheelchair, lap belts were in place. Where people used oxygen we saw risk assessments were in place which included the collection and changing of oxygen cylinders. There were clear signs in place by people's bedroom doors to alert staff of the risk of oxygen. For those people who were at risk of falling from bed, crash mats were in place. Other risks identified included choking, waterlow and MUST (weight monitoring).

Staff had completed safeguarding vulnerable adults training. Staff we spoke with were able to tell us about the different types of abuse and the signs that might indicate abuse. When we spoke to staff, they had a clear understanding of their responsibilities to report any concerns and were aware of which outside agencies they could report to as well as their own management team. Staff said, "I have never seen any concerns"; "Safeguarding is to keep every resident safe. For example, proper equipment and protect people from abuse. I would report to the unity manager, line manager or higher if nothing was done"; "I would report anything, no problem. Any kind of abuse is a 'no go'. People are here to be safe and for us to look after them" and "Everyone is safe, I would have to report it and I have not seen any poor practice". We saw systems were in place for safeguarding referrals to be recorded and appropriate referrals had been made to the local authority and the Care Quality Commission (CQC). We saw contact details of who to report any concerns externally, for example, the local authority were displayed in each of the nurses stations and notice boards.

We were alerted to a safeguarding incident which occurred in March 2017. The safeguarding was a result of a whistle blower. An investigation was undertaken by the local authority and the provider. It was found that staff, although aware of the poor practice, had not reported their concerns or acted in the best interest of the best person. We discussed this with the manager and area manager on the day of inspection. They told us actions they had put in place. For example, they had held meetings with staff members and as individuals to ensure their understanding of their responsibility was clear and who to report any concerns to. A robust investigation was still in progress at the time of the inspection. The provider had taken appropriate action to address the issues.

Arrangements for emergencies were in place. We saw people had individual personal emergency evacuation plans (PEEPS). People were rated as red, amber or green, depending on their needs. Details also included the mode of evacuation for people in the event of a fire. These details were stored securely next to the fire panels throughout the home. Staff were aware of the emergency management procedure. This ensured details were available to emergency staff when needed.

Accidents and incidents were recorded and actions to be taken were recorded. Staff told us and we saw accident and incident forms were completed, signed and then forwarded to the manager. However, we found that the system currently operated to monitor falls of people needed improvement. Although these were recorded by staff and entered onto the electronic system operated by the service, it was not possible to analyse these falls to enable the manager to assess people's falls on an individual basis unless they went through each individual form. We discussed this with the manager and area manager. The area manager told us they had raised this with the head office at Barchester Healthcare limited and the current system was being reviewed as it was recognised improvements were needed. The manager told us they had developed a 'falls analysis book' to record all the details and would use this to monitor people's falls.

Records relating to recruitment of staff contained relevant checks that had been completed before staff worked unsupervised in the home to ensure they were of good character. These included employment references, the right to work in the UK and disclosure and barring checks (DBS). DBS checks enable employers to make safer recruitment decisions and prevent unsuitable people from working with vulnerable

people. The provider also had processes in place to check all staff employed as registered nurses were registered with their professional body. This ensured they were qualified to work in the capacity of a registered nurse.

Records we reviewed showed staff had completed a job application form and we saw there were no gaps in a person's employment record. Interviews had been completed; photographic identification and health checks were present in staff files.

We saw good practices were in place for controlled drugs, medicine fridge temperatures and where PRN protocols were in place, these were well written and the guidance was very clear for staff to follow. The system was clear and well understood by the registered nurses. The medication room had a temperature check and a secure controlled drugs (CD) cupboard. We saw a CD book was in place which listed people's individual medicine. Two nurses signed for each entry and the disposal of CD was also signed by two nurses. We saw daily temperature checks were undertaken of the medication room and the fridge to ensure people's medication were stored at the right temperature to keep these effective.

We observed the medication round with one of the nurses at Chalfont Lodge. The registered nurse was diligent and approached people in a calm manner. Staff waited for people to take the medicine before signing the medication administration chart (MAR). Medicine was kept securely in lockable cabinets and in a secure room. Staff were aware of the procedure in place to ensure that medicines were ordered, administered, stored and disposed of safely. They were aware of the protocols in place to administer certain medicines as well as the necessary checks they needed to complete before administering specific medicines.

We received positive comments from professionals regarding the management of medicines. Comments included "The home is really good, very engaged with our support for people's medicine, for example the management of wasted medicine. The home provides staff with protective time to order and receive medicine and follow best practice as per the NICE (National Institute for Health and Care Excellence) guidelines. They also put extra staff on duty when there is a delivery. Staff work well with me, for example, the review of people's medicine to reduce the use of antipsychotic medication. If people are on complex medicines, the home refers them to the consultant who will review the person with the support of their GP".

Good

Is the service effective?

Our findings

Staff had the skills and knowledge to meet people's needs. Staff had completed training which included; safeguarding, moving and handling, food safety, infection control and there had been 90% completion rate. We saw staff training was monitored and triggers were set to remind the manager when individual staff training was due. A training plan was in place for 2017 for staff to attend. Staff told us they were told when training was due.

Staff were complimentary about the training provided and were able to request any additional training they felt would improve their skills and knowledge. Comments included, "Yes I get regular training, online and classroom training. I had health and safety last week and definitely enough training to do my job. They let us know when our training is due to expire so that we can schedule it in"; "The training is fine, we used to have our own trainers, but now have regional trainers and they are fine"; "The training is really good and I have done it all. Barchester are excellent for training"; "Feel competent to look after people"; "Training is very good, learn new things, including specialist care, for example, tracheostomy care. There is enough training, including refresher training and I know what I am doing" and "We get a lot of training, definitely enough and have it every two months roughly".
Staff felt they were well supported to develop their skills. One staff member told us, "I love it here; I started as a nurse and got promotion within six months. I had further development opportunities, tried another position within the home, but decided I preferred my role as a nurse. They were really good about this and still give me opportunities to develop my skills"; "I want to work to care practitioner level and I am being supported by the provider to do this. I am really looking forward to learning different things" and "I came in as a care worker, I am now a senior care worker, so pleased and have new responsibilities".

Staff also told us "I am very pleased with the support, could not be better"; "We get good support here, my colleagues offer to help out, it's very good teamwork"; "[name] is approachable, I ask if I am doing things right, my question is well received and I don't feel embarrassed to ask".

People and their relatives said they were happy with staff competence. Comments included, "The physio and nurses do a wonderful job, they are all very professional" and "Yes my husband's needs are met, although there are times I have to ask for my husband's nourishment to be replaced when it has run out".

Professionals commented, "Staff are really helpful, they know people really well and know any issues people have. They are really 'on the ball'"; "Staff are very organised" and "Nurses are really good, they do well".

New staff completed an induction and were supported by more experienced staff until they felt confident to work alone. There was a system in place to monitor staff's induction. We saw checklists and competency checks were monitored to ensure the new employee met the required quality needs as a staff member. However, one of the new staff files we looked at did not always have their checklist completed when they had completed certain competency and induction elements. We discussed this with the manager and they agreed that it was not always clear from the records at what stage the staff member was at with their induction. They said they would review the paperwork. We later spoke to the care staff member who

confirmed they had completed these elements as part of their induction. Following our inspection the manager sent us details which showed this had been actioned.

Staff told us they felt supported during their induction. Comments included, "Yes definitely felt supported when going through the induction process".

Staff were supported by the management at Chalfont Lodge. Staff had regular supervision and an annual appraisal. This was confirmed when we looked at the supervision matrix. Staff told us it was an opportunity to discuss any concerns and development needs. Comments from staff included, "Very good here, well supported by [name], any problems I go to them and they listen and we discuss at my supervision. We also talk about any issues and how we can sort these out"; "I have regular supervisions and I also carry out observational supervisions in my role"; "I have bi monthly supervisions, we discuss my training needs, incidents and we will look at previous areas which were not resolved as part of my development".

We saw the provider had an employee of the month scheme. Staff were nominated by people and their relatives at the home. This was a positive way of celebrating success and recognising the hard work of staff.

People were supported in line with the principles of the Mental Capacity Act 2005 (MCA). MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We saw people's capacity had been assessed in their care plan. People were supported to make decisions on their day to day care. Care plans outlined whether people had capacity to make decisions on care and treatment, and where appropriate, a Lasting Power of Attorney was in place which had been authorised in accordance with the MCA. We saw one of the units, Sunningdale, did not have the detailed assessments other units had. The manager told us they recently adopted the local authorities MCA assessment form. This had been implemented in the home, but Sunningdale still had some files which needed updating. They said they the deputy manager was currently working through these files.

We spoke with staff about their understanding of the MCA. Staff demonstrated a good understanding of the MCA. Comments included, "The MCA was designed to protect people who cannot make decisions themselves"; "Everyone has to have an assessment if we think they cannot make decisions. We encourage and help people make a decision in line with their 'best interest' This can then lead to a DoLS as we may be depriving them of their liberty"; "It's about people who may struggle to make decisions, for example what to wear. We follow process, best interest and DoLS" and "We always assume capacity, an assessment is done involving the person, their family and professionals".

The management team demonstrated a clear understanding of their responsibilities in relation to MCA and Deprivation of Liberty Safeguards (DoLS). DoLS applications had been made to the supervisory body where an assessment had identified the person lacked capacity to consent to the deprivation. There was a mental capacity assessment which identified the person lacked capacity to understand risks. DoLS applications had been made to the local authority and best interest decision meetings had been held with the appropriate professionals, relatives and management at Chalfont Lodge. For example, covert medicine administration and the use of a lap belt in one person's wheelchair. DoLS applications were kept under review to ensure that people were being supported in the least restrictive way. We spoke with staff members and they were able to tell us which people were subject to a DoLS. This meant people's individual needs were known to care staff.

We saw people's care plans included consent details. For example, consent to having their photograph taken and used in their care file. Where appropriate a "Do not attempt resuscitation" (DNAR) forms were in place for individuals. Where people did not have the capacity to make these decisions we saw professionals and staff were involved and had authorised these decisions.

People had enough to eat and drink. They told us they liked the food and could get other options if they did not like the food on that day. Two people asked for egg and chips instead of the choices on the menu and this was met. They said they could get salads or cheese on toast, baked beans or sandwiches if they wanted as they sometimes did not want a large meal. Comments included "The food is fine and staff assist me with my food, which I appreciate well"; "Food is good"; "Food is ok some of the time. There is too much fish on the menu, but I can have cheese on toast or an omelette or salad if I want". We saw tea, biscuits, cakes and fruit were available to people throughout the day.

We saw records which showed people's nutrition was mainly monitored. People were regularly weighed to monitor their weight and actions were taken to address any risks. Staff were aware of people who were on special diets. We saw there was a list of food and dietary preferences in the kitchenette based on the units. There was also SALT (Speech and Language Team) recommendations on the type of diet people required to aid staff during meal times as well as a reminder to staff to only dish the meal when people were ready so as to ensure that people had hot meals. Staff told us this enabled them to ensure people received nutrition based on their specific assessed needs.

We saw menus were displayed in a holder in the dining room. People were offered the choices of the day and those who struggled to make a decision, were visually shown the choices available to assist them to make their decision. People were asked their food choices, this included the starter, main and sweet options. We observed the lunchtime experience for people. Staff were very caring and knew people's individual needs. Tables were laid up with napkins, condiments and fresh flowers. We saw people had the option of drinks, which included a glass of wine if they wished. Overall people's experience was positive. People who required support to eat their meal were supported by staff who were patient and caring. For example, we saw one nurse who gently wiped the person's face as the food had dribbled down their chin. People were offered protective clothing and staff interacted well with people. Staff knew people's individual needs and when assisting people with their meal they took their time and were attentive to people's needs. They sat at the person's level and explained the food they were assisting the person with. We were told as part of Barchesters' dementia programme that coloured plates would be introduced for people with dementia to enhance their experience at mealtimes.

People who had their meal in their bedroom were supported in an unhurried way and they were encouraged to eat and drink and staff were attentive. We asked people if it was their choice to stay in their room and they said it was. People were able to have their meal where they wished. For example, one person sat on the decking area of the home. They told us food is "Good and bad. I have a special diet and sometimes they run out of the food I want. Today they have no cucumber, I am not happy". We discussed this with the manager and we were told they were unaware of the shortage. They asked the chef and were informed the produce had not been delivered as requested. They said if they had known, they would have sent a staff member out to get the food for the person. They reminded the kitchen staff that if a something is not delivered which affects people's choice, they need to inform the manager.

We spoke with the chef. They knew people's individual preferences, including health needs and allergies. They knew people who needed their food pureed and those whose diets needed fortifying to maintain their nutritional intake. They said "I fortify food with double cream or butter to maintain people's weight. I make milk shakes with full fat milk also. But I do recognise those who need less calories as I use skimmed milk

powder which is high in protein but low in fat". They told us that they were updated weekly by the nursing staff re any changes in people's nutrition needs. The head chef meets with people and their relatives on a monthly basis to discuss the menu. They also said they use professional magazines to get ideas on recipes and how to improve nutritional options. We saw the chef regularly checked fridge and freezer temperatures. This meant the chef recognised the need to keep the food for people at the right temperature and to keep people safe.

Due to the complex needs of people at Chalfont Lodge, professionals regularly visited and monitored people's care. During our inspection we saw three professionals visiting to support people with their care and to support staff to deliver safe care. For example, a respiratory nurse came to check on one person who received oxygen. We also saw evidence of dietitian input for people. We saw an action plan had been put in place following the identification of improvements by health commissioners and the local authority. We have asked the manager to update us with progress on these actions. Following the inspection the manager sent us an updated action plan which showed they were actively addressing the action points.

People's care plans showed people had been supported to see health professionals, for example their GP and each visit was clearly recorded with details of how to look after the person. Relatives told us they were kept informed of any health concerns regarding their relative. Comments included, "[name] fell down two or three weeks ago and broke their hip. When I got here, [name] had already called the paramedics and GP. I followed [name] to the hospital" and "[name] sometimes gets a urinary infection. She can get the antibiotics if she needs generally the same day or the next day".

Good

Is the service caring?

Our findings

People, and relatives told us staff were caring. Comments included, "When my family member was in hospital, [name] would phone me regularly to see how my family member was"; "All the staff are kind, they are fantastic without a doubt"; "Sometimes I get upset and cry. Staff come and sit with me and will give me a cuddle"; "[name] can be difficult and sometimes aggressive. He may need one or two care staff and they are all good" and "Mummy cannot praise the staff enough, or how kind they are. Mummy calls [name] 'Dan the man', she cannot praise him enough".

Professionals told us "Staff make a real effort with people. For example, getting them to the day room". Staff said, "I go beyond for people, I like coming to work here"; "I do my job well, people are very fond of [name]. They make them feel safe and want us around all the time" and "I will greet people, give them their breakfast and talk about the days plans".

During our inspection we saw one person who was having muscle spasms. Two members of staff supported this person in a very caring way and supported them to make them comfortable. We saw another staff member approach another person who was upset and disorientated. They spoke to the person very calmly and with compassion. We heard them say "Come on lets have some me and you time? Raise your thumb if you want to? Ok, let's go to your room". We saw one of the laundry staff team who recognised one person was wearing the wrong jumper. They approached the care staff and asked them to change it. Staff were seen to come into one of the lounges and change the television channel for one person. This appeared to calm the person's mood. We saw the day and date was displayed in the home along with clocks on walls in lounges to help people keep orientated.

We saw the activity co-ordinator was professional and responsive to people's needs. Although some of the people could not communicate their wishes, staff knew the person's needs. They showed compassion, dignity and respect. Staff told us how they would make time to sit with people and read the newspaper with them and do the crossword. They said "I encourage them to use their brain. I love the end result of getting someone up, getting them clean, letting them choose their clothes as it's them that are going to be wearing them all day. I will not take choice away from anyone".

Choice was maintained for people. For example, people told us they could stay in their bedrooms if they wished or could be taken to the lounge or dining area of their choice. Comments from people included, "I have no problem visiting any time I choose. We are always welcome and treated nicely"; "My husband needs to be reminded to have his shave, he forgets due to his memory problems. Staff do their best to assist him, but could give him more attention"; "Carers do understand the care I require. They are very nice and treat me well, except agency staff, they don't seem to know what I want and when to put my light on or off and pull my window curtain for the shade". Another person said "There are too many agency staff and they don't care". We were told by the manager and staff that the use of agency staff had reduced considerably and now were developing a consistent staff base.

We found staff were polite to people, each other and the inspection team. They greeted us in a very polite

manner and introduced themselves. Staff said, "I always ask first before I help people and let them try and do things themselves, food choices, choose clothes, even down to helping someone clear their teeth. I held the electric toothbrush and so we did it together".

Staff members told us caring was important to them. One care staff member said "I care about the person's feelings. I want them to wake up like I wake up, fresh, happy and do the best I can all the time for people"; "I show empathy with people, I want to help them" and "I like to create a good bond between people and staff".

People and their relatives were mainly involved in their care and reviews of their care. The care files we viewed showed they were written with the involvement of the person and their relatives. We saw consent was obtained from people when using specific pieces of equipment, for example, bed rails and details of their consent was present in their care plan. One person told us "I like helping. They spoke about the daffodils that they had helped to put in vases for the dining room".

Care staff understood consent for people and their choices. They said "[name] is always given the choice to choose the colour and dress to put on. We open the wardrobe and allow her to choose what dress to wear and what cardigan to put on. People and visitors commented, "I enjoy staying in my bedroom and watch television, it's my choice" and "I can use my mobile to text my family".

People's rooms were personalised, they were able to bring in their own furniture and belongings to ensure their room was homely.

People's dignity and privacy was respected. When staff spoke about people they were respectful and they displayed genuine affection. The language used in care plans was respectful. We saw one resident was moved with great care and respect. The member of staff explained what they were doing. People and visitor's comments included "I do feel I have enough support, dignity and love from the staff and others workers within the building"; "[name] always looks clean and washed nicely"; "Dignity and respect if definitely present and they (staff) think about the person's needs"; "I use a towel to cover people and I respect it if they refuse, I will keep encouraging them and return to ask again"; "I treat people how I want to be treated, for example, ensuring they have no food left on their face and they are properly clothed. I want them to look nice like other people"; "I ensure peoples independence is maintained, I always let them try and to it themselves first. I encourage them to be independent when eating and use a walking frame instead of a wheelchair" and "I know not to speak about people's personal needs in public, for example, I won't talk about their continence needs if they wear a continence pad".

We saw staff knocked on people's door before entering their bedroom, even when the door was open. They told us how they promoted people's dignity by ensuring the person is covered during personal care, taking their time with people and explaining how they were going to support them. They also said they ensured people's doors were closed when they delivered personal care to people. People were dressed appropriately on the day of our inspection. Their clothes were clean and staff made sure people wore jewellery of their choice. We also saw people had daily newspapers in their room to enable them to keep up to date with news.

We saw people's confidentiality was maintained. When nursing staff were not at their nurse station, they ensured the door was always locked to keep people's files secure. Also in the dining room people's specific needs were kept confidential as the cupboards in the kitchenettes had a key code so that only care staff could access the personal details of people.

Requires Improvement

Is the service responsive?

Our findings

People were assessed prior to moving to the home and assessments were used to develop personalised care plans.

People had comprehensive care plans in place which recorded their needs. However, supplementary records of people's care were not always being completed to ensure people's safety was maintained. For example, repositioning charts. This was mainly on the Sunningdale unit.

Advanced care planning for people was in place. This mainly detailed the person's specific wishes. However, we saw one person's care plan which was not person centred on the Sunningdale unit. It stated 'decision by doctor' as answers to all of the questions about where the person would want their care delivered.

We saw that one person had been assessed as needing weekly weights due to weight loss on 21 March 2017. However, this had not been implemented on the day of our inspection as the last weight check was on 15 March 2017. This was recorded in the 'weight' book on the unit, but not in this person's care records. This person's falls plan needed to be reviewed as it had been last updated on 14 June 2016, but the person had had two recorded falls after that date. This meant people's care records were not up to date and put people at risk.

We saw people's records on the Sunningdale unit needed to be archived. There were records dating back to 2014. For example, professional visit, DoLS documentation, bathing records and accident and incident records. This makes it very difficult for staff to find the latest and most up to date information on guidance of people's care needs and support.

In the care plans we viewed we saw there was detailed information relating to people's life histories, what and who was important to them, their likes and dislikes and there was a photograph of the person on the front of the file. Whilst care plans addressed people's physical and social needs, they did not always involve people or identify goals or aspirations for people. People's specific needs were recorded but we found they were not always acted upon. For example, we found a number of charts to check if a person was safe or required assistance were not completed. Therefore, we were not able to confirm if this person had been checked. Care plan reviews were regular, including risks and some involved people or their relatives, who were encouraged to make comments or amendments to the care plan.

We saw for those people who were not able to be involved in their review, their relative was involved in some cases. One person told us "My husband sees my care plan, if I was not happy with something he would take it up for me". However, on Sunningdale unit we found that although relatives had been invited to attend the review, their non-attendance was not followed up or documented to confirm attempts to involve the relative had failed. We saw one file where the last involvement of the relative was 2014. As there were a high number of people who were either not able to physically or mentally to have involvement it is important that, where possible, the family member is involved to review their care. We discussed this with the unit manager who said they would ensure details of correspondence with families would be maintained in the future. Another

person told us "No, I have not seen my care plan for a while. But I know it's in the office"

We saw the provider had systems in place to carry out an in depth review of people's care. This was called 'resident of the day'. This meant staff would concentrate on one person's care plan for the day to ensure it was complete and up to date. We saw details were discussed at the daily 'stand up' meeting chaired by the manager. Each person had their own 'keyworker'. This was to maintain continuity of care for people. The keyworker role is to be the main contact for the person and their family members. For example, when it was someone's birthday the person would receive a birthday card and a cake to celebrate the event. We also saw regular reviews of people's care plans took place on a monthly basis.

Professionals and visitors told us staff were responsive to people's needs. Comments included "Communication is really good. Staff follow advice given, e.g. thickener and write details in the person's care record. They (staff) always follow recommendations. Staff are good at recognising and acting on changes to people's needs. For example, one staff member recognised a person who was on a puree diet that their condition had improved. They arranged for a further assessment of the person". They also told us how they respected people's wishes as the person told staff they did not want to get out of bed that morning for their appointment. Therefore the appointment was rearranged for the person. One visitor said "[name] is not an easy patient and can be aggressive in the shower and lash out at care staff. I apologise for their behaviour, but they (staff) tell me not to worry, they handle it really well".

We saw where people had specific needs, for example air flow mattresses, details of the person's weight was used to ensure the mattress was set correctly. We looked at six people's records and found the mattress was set at the correct weight setting. We saw records that confirmed mattress checks were completed daily to ensure people received appropriate pressure relief so as to reduce the risk of developing pressure sores. Other good examples of the management of specific needs were Warfarin management, catheter care and tracheostomy care. We found protocols were in place to ensure people who received enteral nutrition were positioned properly whilst their nutrition supplement was in place. Syringes used to flush the PEG were clean and packaging was marked with the opening date. Percutaneous endoscopic gastrostomy (PEG) is an endoscopic medical procedure in which a tube (PEG tube) is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate.

We saw people were encouraged to maintain relationships with their family member. For example, where two people from the same family lived at Chalfont Lodge and with their involvement, they were given bedrooms which were next door to each other. Another example was people were encouraged to meet their companion or friends from another unit in the lounges. This maintained regular contact, not only during activities, but also at meal times.

There was a large garden with a lake and a decking area with ample space for people to sit. We saw people regularly used this space during the inspection. We saw some people chose to have their lunch there. One of them said "I come out here as often as I can". We saw on Memory Lane unit that pictures and names were on people's bedroom doors to enable them to find their way and keep them orientated. There were retro pictures, a singer sewing machine and other tactile objects in the communal areas.

People were supported to spend their day as they chose. They were encouraged and supported to participate in activities that interested them. We saw people had decorated eggs for the forthcoming Easter celebration. These were hanging on a tree in one of the lounges for people to enjoy. On the day of our inspection there was a singer at the home. People were singing along to a Tina Turners' song 'simply the best' and it was very clear everyone in the room enjoyed the event. One person said "I sing my head off, I really enjoy singing". We saw one person was taking clothes off a doll and putting them back on, another

person had knitting wool and buttons in jars next to them. The activities co-ordinator told us that this person liked to sort through the burtons. People were supported on a one to one basis. For example, wildlife sightings took place. We also saw people were supported in their bedrooms with activities. For example, reading the paper to them.

The activities co-ordinator we spoke with told us of the improvements they were planning to make for activities for people. They said they were compiling a 'getting to know me' book. The information enabled staff to know about people's past and tailor people's care to meet their specific needs. They said they were setting up 'rummage boxes' for people. These would contain objects and photographs which were meaningful to the person. This meant staff had items to enable them to strike up a meaningful conversation with people and could relate to people's past history. We saw a potted history of people was recorded for staff to use. This showed how many children they had, including grandchildren and a quick narrative about the person. We were told they were also liaising with a dementia specialist for one person who had lost their sight and were blind. They said they were going to get some smelling sensory items for this person. One person told us how they had made a money box for their first great grandchild and how proud they were of this. We were also told that a monthly took place between the activity co-ordinators and people. This was to identify what people would like to do. We saw the dates of the forthcoming meetings had been scheduled and displayed for people in the lounge. They said they were planning to purchase more of their own equipment, for example, Boules, so that they could provide a more responsive activity for people.

Some people at Chalfont Lodge were of a younger age than the majority of people. Some said they would like more activities to suit their age. One person said "Activities are not up to date for my age; I like arts, crafts and bowling". Another comment was "I would like more musical activities with CD's for example, we could play them to resident's in the lounge. I get so much pleasure seeing residents who have dementia enjoying themselves".

Staff told us they felt the activities for people were good. One said "Much better than other homes I have worked in. So well planned, well thought out and lots of activity choices".

There was a complaints policy and procedure in place. Relatives told us if they had made a complaint and that it was well managed and they had confidence their concerns would be listened to. One relative said "If you have a concern you can talk to the unit manager. I come in during the day, my children visit in the evenings and they would say the same". We saw systems were in place to manage complaints and details were recorded along with actions following the complaint. We saw when complaints were escalated to senior management, these were well managed and clear communication had taken place, along with actions, with the complainant.

One person told us how the manager has responded positively to their complaint. They said they had raised concerns about agency staff and that the manager listened and took action.
Providers are required to comply with the duty of candour regulation. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to registered persons when they are carrying on a regulated activity.

At the time of the inspection, the service had an appropriate duty of candour policy. The document provided clear steps for the management to follow if the duty of candour requirement was triggered. The manager demonstrated a good understanding of the Duty of Candour.

Requires Improvement

Is the service well-led?

Our findings

Where people needed specific care needs monitoring, we found these were not always being completed. On the Sunningdale unit we found a number of areas of concern. There were a high number of people were in bed which meant they were at risk of developing pressure sores. There were charts in place to monitor and record people's position to maintain their skin integrity. We looked at three people's records on Sunningdale unit. We looked at the recording for one person between 29 March 2017 and 5 April 2017, a period over eight days. We were told and the care file confirmed that this person needed repositioning every four hours. The care plan stated 'Check four hourly and if asleep, needs to be turned as can only turn them self when awake'. On five occasions the chart had not been completed to show that the person's position had been checked or if they were awake or asleep. On 6 April at 17.30 we found this person was distressed and calling out. We saw they were not able to reach their call bell. We asked staff to attend. We looked at this person's positioning chart for the day and found that a check had not taken place at 1700 hrs. We asked the care staff member why they had not been checked. They told us it was because they were serving people their supper. We saw this person required hourly checks as they could not use their call bell. This person's care plan had a risk assessment in place which said 'Unable to use call bell' 'When [name] in their room, make sure hourly checks are done during the day and half hourly at night (keep records)'. We looked at the records of the hourly check and saw that these had not always been completed. For example, on 5 April we saw no checks had been recorded after 1400hrs. On 6 April, we saw hourly checks had been recorded at 0800, 0900 and 1000, but none after 1000. Our check was at 12.30 on 6 April 2017. This meant we could not be confident this person was being checked to ensure they were comfortable, safe and if needed any assistance.

Another person's records showed that over a period of six days prior to our inspection there were four days when their record had not been completed. On the day of our inspection, 6 April, we found in both cases the person's chart had not been completed after 10am in the morning. We looked at another person's positioning chart on 7 April and found their position had not been recorded regularly to ensure they did not develop a pressure sore. This meant we could not be confident people's risks were being managed safely. We raised our findings with the team leader on the unit. They told us they were aware staff did not regularly complete charts and that staff had been reminded to do so. They also told us part of their role was to audit these positioning charts to ensure they were completed and people were safe. They said they were not supernumerary, unlike other team leaders in the home. This meant they did not always have the dedicated time to carry out this check. The manager and area manager told us this was true, but the deputy manager had been tasked to work closely with the team leader as they were relatively new to the role and they would ensure a more robust oversight is maintained.

We saw one person's risks regarding the management of their 'PEG' feed was documented in their care file. It stated, records 'must be signed by two staff members to prevent errors due to over or under inflation of the balloon'. We looked at the person's records from September 2015 until January 2017. On each occasion only one signature was present. We noted the next check due after August 2016 was 26 November 2016. However, the chart had not been completed for this date. This meant we could not be confident staff had followed guidelines to monitor this person's specific care need. On the same unit, Sunningdale we found the

PEG care had been recently changed to a weekly rotation for people when a PEG was in situ. However, staff could not explain what the rationale was and why this change had been made to all people with a PEG. They told us this was due to a recent safeguarding. We also found that staff did not always record when the PEG site had been cleaned. We saw one person whose risk assessment said the PEG is to be rotated daily, however, we were told this had been changed to weekly. Another person had a care plan for their PEG. This stated that the PEG had no balloon and was therefore long term and needed to be changed in hospital. However, the PEG record sheet still stated the PEG should stay in for three to six months despite the PEG in situ not requiring this. This showed people's risks were not being managed safely as their care records were always accurate and did not reflect people's current needs and support required. This left people at risk of inconsistent care.

People who have diabetes are at risk of contracting infection in their lower extremities. This means that it is important that regular checks are carried out to ensure people's health is maintained, in particular their feet. Although staff told us they checked people's feet regularly who had diabetes, this was not being recorded.

We saw another person's care records stated that there were specific areas which staff needed to apply topical cream. However, on the chart which monitored this, there was no clear instruction for staff to follow. Therefore, if the staff member was new or not familiar with the details, this may be missed. We spoke with the deputy manager. They agreed that more detail was needed and said they would address this straight away.

It was not clear whether people were receiving the correct dose of their medicine. We found one person's PRN, as required medicine, form did not contain the maximum PRN dose in 24 hours and when to escalate any changes to the GP.
We saw one person who had epilepsy and their medicine was given covertly, in food or drink. We saw this person had suffered a number of seizures in March 2017 where it had been agreed to give their medicine covertly. However, the covert protocols were not always specific as to how much food the medicine was to be given. The record said, 'mix in one bowl of soup; mix in 100mls of orange juice; mix in yoghurt'. The risk here is that if the covert medicine was put into a high volume of drink or food, the person may not complete the dose, this may increase their risk of seizures if medicine is not received in full. We spoke to the unit lead, they said "His epilepsy is very complex. We have referred him to a geriatrician".

Systems were in place to monitor the quality of the service. Audits were carried out and included audits of: care plans; risk assessments; medicines; health and safety and people's weights. These audits were reviewed by the manager and senior management at Barchester Care. We saw that areas of concerns regarding the completion of charts for people were identified in November 2016. However, the same areas were identified at our inspection. This meant audits were not always effective as they had not addressed the areas of poor record keeping. We saw that target dates were set and the responsibility had been allocated. However, although the date of completion had been recorded it was not clear who had checked to confirm actions had actually been taken. As there were a number of anomalies and actions needed identified, to ensure improvement is made and actions robust, the provider should include further checks to demonstrate changes have actually been implemented.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw communication processes were in place to keep heads of department staff up to date. Handover meetings, known as 'stand up meetings' took place. Staff were provided with updates regarding individual people's needs by each unit's representative or department heads. Updates also included environmental

issues. For example, recent electric work undertaken at the home. Details discussed included people's risk areas, training, housekeeping updates, forthcoming audits and professional visits.
There were regular handover meetings between care and nursing staff. These took place on each shift change. We saw these meetings were recorded to enable staff to refer to details throughout their shift. Each individual person was discussed, including people's moving and handling needs, nutrition, infection control and general updates for each unit. Staff told us, "Information is forward by my colleagues"

The manager, deputy manager and the team provided us with the documents required which demonstrated an open culture.

We saw there was a suggestion box in the reception area to enable people and visitors to provide feedback. Senior management told us that there was an employee helpline available for staff to use if they had any concerns or were not happy with the way the home was operated.

Staff gave mixed reviews about management support. Some felt supported but others felt the manager and deputy manager could be more visible and hands on. However, we did receive positive feedback from visitors and staff. Comments included "In the beginning of [name] moving here, things were not so great with his care, but there have been a lot of improvement since then. Presently, the family and others on the whole are very happy with how things seem, although it took a while to get to this point". Staff comments included, "All staff are approachable, I have a good relationship with the manager"; "The manager is ok, but I normally deal with the nurses"; "I am very well supported by the head chef, any problems I know I can go to him and he listens"; "He (manager) is fair, but strict which is right. It's give and take, we sort out any misunderstandings and it's always on good terms"; "My unit manager makes everyone feel happy, they sing to us!"; "Manager is lovely, very approachable, anything you need he is always willing to help"; "The support is good, if I have a problem I will go to the unit manager or manager, everyone is helpful"; "Manager is really fair and is always available"; "It's alright here really, support is ok" and "There is definitely an open culture and you are listened to".

Nurses and care staff told us they had meetings but these were very seldom. One staff member said "They happen three times a year". Other staff said, "A few times a year, I can't exactly say how often as I am not sure" and "I have had one staff meeting since I have been here. May have missed others though". The manager provided us with various copies of minutes of meetings. These included staff meetings and unit meetings. These were well detailed and included action points to be followed up or actions taken to date. They also showed there was an open culture which allowed staff to raise any concerns about their work or anyone who lived at Chalfont Lodge.

Comments about the overall management at Chalfont Lodge included, "My overall opinion about this place is positive for the carer, staff and people. Thank you so much for coming in to see how the management are caring for us"; "Very good team work"; "It's a lovely place Chalfont"; "Very well run, if my mum had to go into a care home I would willingly put her here"; "The management and staff are welcoming and caring"; "Nice atmosphere to work in. Whole structure and practices are good. Staff are very pleasant"; "The home is well run"; "It's good to work here, everyday it's a new day for residents and us"; "Leadership is good, but sometimes I do feel you have to say things several times"; "It's a happy place, clean and fresh"; "It's better now we have stability of management" and "It's well run, you can see improvements for people, it's nice to see them smile".

We saw an annual survey was sent to people and their families. The last one was October 2016; the results had been received in March 2017. Overall comments about the service were good. The manager told us they would be reviewing the results to identify areas for improvement and work with people and families to

achieve better quality care.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. The provider was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.

Throughout our visit management and staff were keen to demonstrate their practices and gave unlimited access to documents and records.

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 17 HSCA RA Regulations 2014 Good governance The provider did not have a robust quality assurance system in place to effectively monitor the safety and quality of people's care.