Beech House Care Homes Ltd

Chestnut House

Inspection report

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Ratings

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

Overall summary

We inspected this service on 13th October 2015. The inspection was unannounced which means they did not know we were coming to the service to undertake an inspection. The service was last inspected in July 2014 and was compliant in all five outcome areas inspected.

Chestnut House is a care home providing personal care and accommodation for up to 19 older people. No nursing care is provided. On the day of inspection there were 17 residents using the service.

A registered manager was in post and present on the day of inspection. 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.

Staff ratios were adequate to meet the needs of people accessing the service. The service benefitted from a stable staff team and robust recruitment processes were in place to ensure that the right people were appointed when this was required. Proper recruitment checks were carried out, including checks with the Disclosure and

Summary of findings

Barring Service (DBS). Both staff and management had an understanding of safeguarding and knew how to report an issue if they had concerns. This meant people were protected from the risk of unsafe care or treatment.

Risks had been identified with particular individuals and staff were aware of how to manage those risks.

Measures were in place to prevent the spread of infection with adequate hand washing facilities and appropriate signage. Medicines were obtained, stored and administered safely.

Staff were positive about the service as it ensured that all staff were trained and they invested in the personal development of the staff. Staff spoke highly about the training and the supervision process which was undertaken with them on a regular basis. We saw that appraisals had been held with staff but these weren't always in line with company policy.

The registered manager and other staff had a good understanding of the Mental Capacity Act 2005 (MCA) and DoLS legislation and were able to describe when this would apply. We were shown evidence of DoLS applications submitted by the provider and authorised by the supervising authority. This demonstrated that the provider was working within the correct framework to ensure peoples' rights were protected.

People were complimentary about the food on offer at mealtimes. Catering staff displayed knowledge about the various diets catered for and the home had been awarded a score of 4 out of 5 in the Food Hygiene Ratings, run in conjunction with the Food Standards Agency and the local authority.

We found that care plans contained information about individuals which would assist staff to deliver person-centred care. There were some good examples of staff involving residents in their care and of residents having choices with their daily routines.

There was an activities co-ordinator employed at the home who arranged entertainment, outings and activities for those wanting to take part.

Resident meetings were held on a regular basis. The provider sought the views and opinions of people using the service with regards to relevant topics concerning the home and care provided. There was a system in place for the manager to address complaints made to the home.

People spoke highly of the registered manager and staff felt supported in their roles. A quality survey had been initiated by the manager and responses provided by residents and relatives. People were positive about the service although some of the suggestions made by residents had not been actioned at the time of the inspection.

There was a system of audits in place but these did not always identify areas for improvement. We identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activites) Regulations 2014.

There was a Business Continuity Plan in place which outlined contingency arrangements following a possible disruption to the service.

In relation to the breach mentioned above you can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Staff understood their responsibilities in relation to safeguarding and had received training.

Risks had been identified for individuals .

A thorough recruitment and selection process was in place. Staff recruited had the right skills and experience to support people living in the home.

Medicines were obtained, stored and administered safely.

Good

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

Staff displayed knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards and were aware of recent changes.

Supervision was undertaken but appraisals were not always in line with company policy.

Menus were varied and choices were available.

The design and layout of the home was not optimal for the support of people with a diagnosis of dementia.

People had access to healthcare professionals.

Requires improvement

Is the service caring?
The service was caring.

Staff were respectful and considerate.

The home had a Dignity Champion and dignity and privacy were promoted in the home.

Residents were given choices and involved in their care.

The provider had been awarded The Six Steps award in end of life care.

Good

Is the service responsive?
The service was responsive.

Care plans were reviewed on a monthly basis.

Risk assessments were formulated in response to changes in the needs of individuals.

Good

Summary of findings

Recruitment of a person with the ability to speak a particular language to assist communication with an individual at the home.

Evidence of regular residents' meetings and evidence of action taken.

Is the service well-led?

Requires improvement

The service was not always well led.

People living in Chestnut House, their relatives and staff spoke highly of the registered manager.

Policies and procudures were in place and staff were aware of these.

Audits or quality monitoring tools were not robust enough to assess, monitor and improve the quality of the service.

Chestnut 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 13th October 2015 and was unannounced. The inspection team included two adult social care inspectors and an Expert by Experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home including any statutory notifications submitted by the service. A notification is information about important events which the provider is required to send us by law.

During the inspection we were able to speak formally with three people living in the home. We also spoke to five others throughout the day. Inspectors used observations and listened to interactions that occurred whilst on site. We spoke with eight members of staff, including the registered manager and the senior carer. We also spoke with two relatives visiting that day and with two district nurses.

We observed care and support provided in communal areas of the home. We reviewed the care records of four people who used the service, medication administration records, accident and incident logs, personnel files and staff training records as well as a range of records relating to the management of the service. We looked at the environment including the kitchen, laundry, bedrooms, bathrooms and communal areas and the outside garden space available.

Good

Is the service safe?

Our findings

During this inspection we found that people were protected from risks to their health and well-being.

We reviewed four care plans whilst on site. One contained a comprehensive risk assessment in relation to challenging behaviour displayed by a person living in the home. It directed staff with what to do and what action to take to minimise the risks presented. Following a number of falls by a resident a care plan contained a recent falls risk assessment. Again this highlighted to staff the risk of the person trying to mobilise without appropriate walking aids and identified ways to minimise this risk.

People were protected from the risk of unsafe and inappropriate care by staff who demonstrated a good understanding about how to safeguard adults from abuse. People living in the home felt safe. One person spoken to said, "I've been here eighteen months. I was in a warden controlled (flat) but I feel more safe in here." Another said, "I never have any worries about safety," whilst a third resident added, "I feel safe here. I've nothing to fear." A relative we spoke to who was visiting the home at the time of inspection was very complimentary. They told us, "My relative came here a year ago, thanks to God. I know she is safe in here."

Staff spoken with and the registered manager understood their responsibilities in relation to the safeguarding of adults and staff confirmed they received training in this aspect. Staff had received up to date safeguarding training and had a good understanding of the procedures to follow if they witnessed abuse or had an allegation of abuse reported to them. A potential safeguarding incident at the home had been reported by external professionals earlier in the year. The registered manager could evidence that there had been liaison and co-operation with the local authority safeguarding team, who decided after initial investigation that the incident did not warrant progression through the safeguarding procedures.

A senior member of staff spoken to said, "I've just completed a safeguarding course. I found it useful and it gave me a better understanding." Another member of staff was aware of the home's Whistle Blowing policy and explained in detail the procedures she would follow in the event of a whistleblowing incident. This demonstrated that staff would have no qualms in reporting incidents or working practices that might jeopardise the safety of people living in the home.

Staff rotas showed that there was consistently enough staff on duty with the right competencies and experience to keep people safe. People who used the service agreed. They told us, "I think the home is well staffed. I've never had to wait for help", and, "If I need it, help is there."

A relative told us that on one occasion there had been a shortage of staff at handover as someone had rang in sick. They informed us that the manager had arranged for another member of staff to cover the shift, ensuring the safety of people living in the home.

A thorough recruitment and selection process was in place which meant staff recruited had the right skills and experience to support people living in the home. Three personnel files we looked at were organised, in good order and contained relevant information relating to the recruitment and employment of staff. All files we saw contained a Criminal Records Bureau (CRB) check and appropriate references which evidenced that these staff were safe to work with vulnerable adults.

The service had made the decision to undertake a newer Data and Barring (DBS) check on every employee within the service. This process had been started with the two members of staff employed the longest. We were told that these checks would be repeated every three years, ensuring that people who used the service would not be exposed to those deemed unsuitable to work with vulnerable adults.

We looked at systems in relation to the administration of medication and found that the provider had safe arrangements in place for managing people's medicines. Medicines, including controlled drugs, were stored securely and safely and access to these was limited to appropriately trained staff.

Each person had a photo on file at the front of their medication administration record (MAR) which meant that staff administering medication could easily identify the individual, helping to reduce the likelihood of errors. A person in the home had expressed a wish to self-administer eye drops.. A risk assessment had been undertaken, was contained in the medication file, and had been audited to

check that the person still wanted to self-administer and that it was safe to do so. This meant the home promoted people's independence in a way which maintained their safety and minimised risk.

Disposals of medicines which were no longer needed were dealt with on a daily basis. The senior carer was able to demonstrate this as one person had been in hospital on the morning of the inspection. Each tablet contained in the sealed pot of morning medication had been individually listed in the disposals book and the whole pot placed in the container identified for the disposal of medication. This stayed there until collected by the pharmacy. Unused medication was not allowed to build up and this practice further reduced the possibility of errors when administering medications. We noted that the disposals container did not have a lid and brought this to the registered manager's attention. A tamper-proof, lidded receptacle is better practice in order to safeguard both staff and residents. The registered manager told us they would rectify this by speaking to the pharmacy and sourcing a more appropriate container. We can check this at our next inspection.

The control and prevention of infections was well-managed by the service. There was an infection control lead and staff we spoke with were aware of the role and could name the responsible person. We were on site at 9.30am before the arrival of the manager and saw that where people were up and having breakfast, these rooms were clean and tidy with no malodour. When asked about the cleanliness of the home a relative said, "This is a very clean home with a good atmosphere."

The cleaner was seen checking there were enough supplies of gloves and protective aprons in communal bathrooms as part of her duties. Stocks of disposable aprons were stored in metal holders fitted to toilet and bathroom walls and were easily accessible for staff. Staff were seen throughout the day wearing personal, protective equipment. Signage around good hand washing techniques was noted in communal toilet areas and waste bins in these areas were operated by a foot pedal and were yellow, the best practice colour for clinical waste material.

There was a robust infection control policy in place that included advice and guidance for staff around healthcare associated infections such as clostidium difficile (C.Diff) and methicillin-resistant staphylococcus aureus (MRSA). We were told on arrival that a person living in the home was waiting for results back from a recent C. diff test and, despite not knowing the outcome of the test; staff were taking appropriate precautionary steps in caring for this person in their own private room. This meant people were protected from unsafe care and treatment because the provider had robust policies in place to direct and guide staff.

We saw that mechanisms were in place to record accidents and incidents. A person living in the home had suffered an accident the previous evening and an ambulance had been called. We saw that an accident form had been completed, the care plan had been updated reflecting the fall and treatment received and staff were informed at the morning handover session.

In relation to the safety of the premises a fire risk assessment done by the Greater Manchester Fire Service in February 2015 resulted in a rating of non-compliance as the fire detection system was deemed to be inadequate. We could see that the home had produced an action plan and had addressed the issues raised.

Training records showed that 14 staff attended fire safety training in June 2015 and staff we spoke with were able to relate what action they would take in the event of a fire.

A Personal Emergency Evacuation Plan (PEEP) was available for each person in the service and outlined how many staff were required to fully evacuate individuals safely should a fire occur. Through conversations had with the registered manager it was clear that they recognised the PEEPS needed to be person-centred and accurately reflect all stages of evacuation, including the last stage to a place of safety outside, which would probably be undertaken by the emergency services.

Staff confirmed that fire alarm tests were undertaken every Friday and we saw that the required annual service checks had been done to portable fire-fighting equipment.

Requires improvement

Is the service effective?

Our findings

People and their relatives were complimentary about both the service and the staff. A person we spoke with told us that staff knew how to look after her relative. “My family feel very comfortable with the care at this home.” Another person commented, “The staff are nice. They always speak pleasantly with me.”

One person highlighted how staff listened to them. They told us, “I tell staff how I like to be cared for and they listen and do what I want.”

Staff records were well organised and the service could demonstrate a robust training programme. There was investment in all staff employed at the home with regards to training and staff we spoke with were positive about the training on offer and appreciated the opportunity for self-development. One employee told us, “I've completed moving and handling, fire, safeguarding, medications and end of life care in the last 12 months.”

A training matrix supplied demonstrated that staff had accessed appropriate training in subjects including safeguarding adults, moving and handling, fire safety, medication and infection control. We saw that staff had also received training in Dementia Awareness but noted that this was over a year ago for some staff and over two years for others. Staff would benefit from a refresher session in order to update their awareness and knowledge of dementia.

Supervisions were undertaken in line with company policy and staff appreciated the contact with and input from the manager. “I have regular supervision with the manager. She's always available if I have any problems.”

We saw that appraisals had been undertaken on staff in January 2015. The regularity of appraisals was dictated by a scoring system in place. A member of staff had been given an appraisal and based on the score achieved a second appraisal had been due in July 2015, however this had not yet taken place.

The Manager and other staff understood the requirements of the Mental Capacity Act (MCA). The MCA provides a legal framework for acting or making decisions on behalf of individuals who lack the mental capacity to make specific decisions for themselves.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring if there any restrictions to their freedom and liberty these have been authorised by the local authority, to protect the person from harm.

A senior member of staff was able to outline the DoLs process and explained about the involvement of the coroner following the death of a person in a care home subject to a DoLS. They displayed a good understanding of DoLS, including the recent changes introduced to the process. The manager had made three appropriate applications for a DoLS to the Supervising Authority and these had been authorised. This meant that those people who used the service unable to make certain decisions about their care were protected from harm.

The provider had suitable arrangements in place that ensured people received good nutrition and hydration. The four care plans we looked at had risk assessments such as the Malnutrition Universal Screening Tool (MUST). These had been used to identify specific risks associated with people’s nutrition and were reviewed on a monthly basis.

We saw that there was a four week menu in place with the main meal being served at 4pm. There was a diet list available in the kitchen for all catering staff. This highlighted the individual needs of people living in the home in relation to food and we saw that staff were aware to cater for a variety of diets including celiac, diabetic, soft, fortified, pureed and halal. The cook told us that they received training specific to their role and also participated in other training. They had recently attended an infection control training course and found this knowledge useful when away from the kitchen environment walking round the home gathering people’s menu choices.

We saw that the daily menu was written on a blackboard in the dining room. The lunchtime meal was served at midday and consisted of home-made soup and bread rolls. After this people could choose either a slice of home-made cake or ice-cream. We saw that drinks were served throughout the day. At lunch time residents had access to jugs of fruit juice on the tables or were offered cups of tea as an alternative.

The laundry area was a clean and tidy environment and well organised. An audit undertaken by the manager in

Requires improvement

Is the service effective?

August 2015 did not identify any follow- up actions. One person we spoke with spoke highly about the service. “Staff wash my clothes and keep them nice. I always get my own clothes back,” they told us.

People were supported to maintain good health because we saw that they had access to a variety of healthcare services for ongoing support. We spoke with two district nurses who visited on the date of the inspection. Both confirmed that there was good communication between GP's, staff and the nurses. The care plans we looked at documented successful joint working with professionals such as GP’s, district nurses, tissue viability nurses and representatives from the Speech and Language team (SALT). We were told by a visitor that their relative had access to a podiatry service and was receiving regular foot care treatment due to the person having diabetes.

The design and layout of the home was not optimal for the support of people with a diagnosis of dementia. Whilst there was some signage, for example on bathroom and toilet doors, this was limited. Bedroom doors had names and room numbers on them but nothing meaningful, like photographs or personal effects, for people living in the home.

Our observations showed us that the building environment was not ‘dementia friendly’. There are ways to modify buildings to better accommodate those living with dementia in residential care, for example, picture signage, the use of wall and floor colour to aid navigation and memory boxes to stimulate memory and promote discussion. The premises required more work to ensure it was fit for purpose as a dementia-friendly environment.

On arrival we were shown to the activities room on the first floor. This was a large room, initially cluttered with a number of wheelchairs stored in there. These were moved throughout the course of the day. The hairdressing salon also doubled as a storage area for hoists and slings. We spoke to the registered manager who agreed to allocate an alternative area of the home for the bespoke storage of equipment so as not to impinge on communal areas of the home available for residents.

The garden area to the rear of the home was a nice sized space. It was evident that this had been used during the warmer weather as there were some plants and flowers growing in raised beds. One person we spoke with told us, “We all go in the garden in summer and I enjoy that.” On the day of inspection the garden area to the rear was slightly overgrown and the path looked difficult to negotiate. The manager stated that one aim for the future was to have the area landscaped so that people could enjoy the garden all year round.

We recommend that the provider ensures processes in place are followed and that staff performance is reviewed as per company policy.

We recommend that the service explores good practice in modern dementia care, such as that produced by Skills for Care and the National Institute for Clinical Excellence, in order to improve the quality of life of those living with dementia.

Good

Is the service caring?

Our findings

People and their relatives told us that all staff were very caring. One person told us, "The staff are nice. They always speak pleasantly with me." A relative we spoke with was a regular visitor to the home and praised the service. "I spend all day here and staff are very loving kind and helpful to my relative and my family."

We saw a 'Daisy' plaque attached on the wall at the front of the home. The 'Daisy' Dignity in Care is an accreditation scheme operated by Manchester City Council, awarded to providers in recognition of their commitment in upholding the independence, choice and dignity of the people they support. The home had been successful in achieving this following a series of thorough assessments and evaluations in September 2014.

The registered manager was the nominated Dignity Champion for the home and staff spoken with were aware of this fact. People living in the home told us that they were treated with dignity and respect. One person told us, "Staff always knock on my door before coming in." Another person added, "Staff are always polite." We saw examples of staff knocking on bedroom doors prior to entering, including staff other than carers. We were told that staff spoke pleasantly with people living in the home.

We saw that the registered manager maintained good relationships with people living in the home. People we spoke with told us "I know who the manager is. If I had a problem she would resolve it." Another person told us that the manager was very good. This highlighted the fact that the manager was hands on in maintaining positive, caring relationships and people using the service felt comfortable with them.

Staff were motivated and happy in their work. We heard a member of staff singing whilst undertaking her duties and all staff were efficient and effective in their roles. We observed lots of positive interactions between staff and people living in the home and saw that staff were caring and friendly.

At lunchtime we saw that there was sufficient care staff to meet people's needs. One carer was seen providing assistance to a particular person, helping them to eat. Throughout the meal the carer chatted pleasantly to the resident, allowing them plenty of time to eat and drink. This was a pleasant, unhurried meal-time experience for the resident. Another carer started to help a resident to eat. As the meal progressed the person attempted to eat by themselves and was successful. The carer recognised this and let the person continue but stayed with them and broke the bread into the soup to make eating unaided easier for the individual. This caring gesture indicated that staff were willing to help people but they were also keen to promote independence in whatever ways possible for individuals.

Staff told us that they always tried to involve people in their care wherever this was possible. They informed us that residents were offered choices with regards to their care and gave us examples. Residents had choices in when to get up, go to bed or to take part in activities. Choices were also offered with regards to daily meals. One member of staff highlighted the flexibility of the service, depending on peoples' wants and needs. "If a resident doesn't want a shower today then we offer them one tomorrow, or later in the evening." This showed that the member of staff was careful to respect people's individual preferences.

The service had a stable staff team and several staff had worked there for a long time. They knew the needs of the residents well and shared this knowledge with others. People living in the home appreciated this and told us, "We can have a good laugh together. I love them all and they are like family to me."

During our observation in the lounge we saw examples of staff being kind and caring to people using the service on the day of inspection. Inspectors saw members of staff interacting with residents who were undertaking a baking activity. There was lots of talk and laughter which created a relaxed and friendly atmosphere. During the lunch time meal we observed staff being pleasant and polite and people were given ample time to eat and were not rushed with their meals. The meal time was a social occasion and it was evident good relationships were in place with staff and people living in the home.

A risk assessment was seen on a person's file. It stated that personal care might be refused by the individual. One of the reasons for this indicated that the individual was embarrassed. The risk assessment outlined ways staff could cope with this without causing any further embarrassment or distress to the individual. This highlighted that the service cared for people and responded to individual needs in a person-centred way.

Good

Is the service caring?

During conversations we had with people living in the home we noticed that two people had difficulty hearing. One person was prescribed a hearing aid but chose not to wear it. Another told us that they had forgotten to put their hearing aid in that morning. We spoke with the registered manager who assured us that staff would be reminded to prompt those who were more independent if they forgot to wear prescribed aids such as glasses or hearing aids. The registered manager recognised that such aids supported communication and enhanced peoples' experiences of daily activities.

The registered manager informed us about the home's recent achievement, the Six Steps Award, awarded to them in September 2015. The Department of Health's End of Life Care Strategy, published in 2008, emphasised the need to raise the quality of care provided to dying people and their loved ones in a variety of settings including care homes. The strategy identified the need for care home staff to receive the training and support to develop awareness and knowledge around end of life and to ensure the provision of good end of life care.

The manager planned to display the award in the foyer and relevant information about the Six Steps programme on a notice board to make visitors and relatives aware. Four staff in the home were nominated leads for End of Life care and this information would be displayed on the notice board for visitors, professionals and other staff. This would provide relatives, visitors and professionals with relevant contact details for any advice, guidance or emotional support should this be required in the future. This again demonstrated the provider's positive, caring approach towards end of life care.

Good

Is the service responsive?

Our findings

The four care plans we looked at contained extensive information and were developed detailing the care, treatment and support needed to ensure person-centred care was delivered to individual people. The pre-admission assessment tool outlined the level of dependency on admission and the care plan was formulated around this.

Entries in people's care plans showed us that their care and support was being reviewed on a

monthly basis. We could see that where changes in care needs had been identified care plans had been updated accordingly and these changes communicated to staff during handover sessions or via the communication book in place.

We saw one individual with a very high dependency score. This had recently increased due to the number of falls incidents. A falls risk assessment had been formulated in response to this change in need and this alerted staff with prompts and actions that might mitigate the risk to the individual.

One example of these good systems was a capacity care plan we saw. This clearly outlined the level of capacity an individual had but recognised that people with dementia were still able to make decisions and staff were fully aware of this. Staff provided responsive care and told us, "It is all about the residents and their own choices." This attitude contributed towards the positive atmosphere in the home.

We were told by the manager that a member of staff had been employed specifically to communicate with and assist a resident whose first language wasn't English. A relative we spoke to confirmed this and added that other carers had also learnt a few words and tried to communicate with the resident in their first language. This was a good example of the responsiveness shown by both the service and staff to ensure people were involved and included in their care and support.

We were told by the activities co-ordinator that resident meetings were held every two months. The most recent one had been held in October 2015 so the notes weren't available at the time of the inspection. A person confirmed that meetings took place and that they were able to make suggestions or change things. They told us, "We have residents' meetings. The staff do take notice of what we say."

We were told by care staff that there was a choice of food on offer and that the cook asked residents for their particular choices on a daily basis. This information was available in the kitchen on the day of inspection and people in the home enjoyed the food on offer. People who used the service told us, "It's very good food here,"and, "I have eggs and bacon if I ask for it. If I ask I get it." Minutes from resident meetings also showed that people had a say in what dishes were on the menu and evidenced that the home promoted and respected peoples choices.

Minutes of previous resident meetings were available for April, June and August. We saw in an earlier meeting some residents had complained that the food was cold when they chose to eat meals in their own rooms. The service recognised that action needed to be taken and food was microwaved immediately before being served to residents in their rooms to make sure it was hot.

One person had requested during one of these meetings a wish to visit a relative at home on a regular basis. This had been facilitated and the activity co-ordinator accompanied them home for a few hours every week.

Links with the local community were encouraged and promoted by the manager and staff. One member of staff told us they were arranging for a school choir to visit the home and hold a carol service at Christmas.

The home tried to ensure the religious and cultural needs of people using the service were met by ensuring people had access to places of worhip. We were told conflicting information about church representatives visiting the home. Comments included,"We don't see a vicar here," And, "I have seen a priest since I've been in here." One person living in the home confirmed that if a priest was wanted staff, " would see to it and get one."

People we spoke with told us about scheduled activities that went on in the home. They told us, "I have seen a singer here and I enjoyed it very much," and, "We also play bingo and skittles in here." We observed five people taking part in a baking activity the day the inspection took place and were seen positively interacting with each other and

Good

Is the service responsive?

members of staff at the table. Others were happy relaxing or doing their own thing. One person who used the service told us, “I like reading the newspaper. Staff get me a paper to read.”

People were complimentary about the activities co-ordinator in the home. People told us,“She's got a lot of patience and is good at her job.”

We saw that people living in the home were provided with relevant information about the service. A Service User Guide dated February 2015, along with a copy of the home’s Statement of Purpose, were visible within the five rooms that we entered, which were all clean, tidy and fresh smelling.

Requires improvement

Is the service well-led?

Our findings

The registered manager had been in post since April 2015 during which time they had focused on building the team and raising the home's profile with relatives, professionals and the external community. The manager was able to demonstrate ways that this had been achieved evidenced by regular meetings for both residents, relatives and staff and the hosting of a Summer Fayre for all the community.

Staff we spoke with confirmed they were happy to work in the service and consistently spoke highly of the manager. "I feel supported by the management." "The manager is very approachable and tries to put things right." "We have regular staff meetings and I'm very happy here," were all positive comments made by staff.

We were told by staff that there were plenty of training opportunities and that they felt supported and received regular supervision. Minutes of staff meetings reflected that these were held every three months and topics for discussion included uniforms, breaks, room checks and paperwork checks. In the July meeting the team had discussed the implications of hot weather on both the staff and people living in the home and how the situation should be best managed if it occurred.

People living in the home were also complimentary of the way the service was run. They said, "I know who the manager is. If I had a problem she'd resolve it,". A relative we spoke with added, "The manager is very good. Everything in the home is fine and my relative is very well looked after here." Another visitor confirmed that a suggestion they had made had been acted upon and two minor complaints resolved.

The Business Continuity Plan was noted to be a good, comprehensive plan as it outlined actions to be taken within the first 24 hours, three days, seven days and then in excess of seven days in the event of any disruptions to the service. Examples of disruptions covered in the plan were bomb threats, extreme weather, flu pandemic and emergency evacuation of the premises.

Emergency contact numbers for all critical services were contained in the plan such as those for gas, electric, social workers, environmental health and the water board along with full contact details for all senior staff. The version we saw was dated February 2015 and staff had signed that they had read the revised document.

We saw that the service had distributed quality surveys that had been sent to residents, relatives and professionals involved with the service. Responses to these surveys were available but there were no dates noted on any forms so it was difficult to assess how recent these were.

Positive comments about aspects of the service were noted including the quality of care, the laundry, activities and the food on offer. The service had asked for suggestions about how it might improve and a relative had suggested a newsletter. The manager was due to explore this idea and also that of a social media web page but needed guidance from the owner and was conscious of the need for consent depending on what content was put in the public domain.

People living in the home had also responded to the survey by asking for particular items to be added to the menu. Some examples of these were curry and real fish and chips. Following our checks made in the kitchen it appeared that catering staff were not aware of these suggestions and the requested foods were not included on the menu.

We saw that the manager completed a series of audits including Food Hygiene, Laundry, Kitchen and Infection Control. The latest audits had been completed in August 2015 and we noted that the infection control audit was especially thorough and an excellent tool for both management and staff. The audit made reference to the Department of Health's information resource 'Prevention and Control of Infection in Care Homes' and correlated the questions asked on the audit with specific areas of the guidance.

A care plan audit that the manager had undertaken was thorough and correctly identified those plans that needed more person-centred references. However we found that the audit did not identify documentation missing from some care plans with regards to minimising risk. For example, management had identified risks within a care plan for a person with increasing dependency needs and challenging behaviour. Whilst staff were aware and were managing the risks these had not been formally recorded.

We identified that systems to assess, monitor and improve the quality and safety of services provided to people at Chestnut House were not robust enough. We concluded that this was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activites) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems to assess, monitor and improve the quality and safety of services provided to people at Chestnut House were not robust enough Regulation 17 (1) (2) (a)