Musgrave Ventures Limited

Chalcraft Hall Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Chalcraft Hall Care Home on 21 November 2017. Chalcraft Hall Care Home is registered to provide care to up to 20 people, some of whom were living with dementia. The service is arranged over two floors, with a lounge/dining area. There were 17 people living at the service during our inspection. This was the first time we have inspected this service.

There was a lack of effective leadership at the service. A registered manager was not 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 and associated Regulations about how the service is run.

People's individual needs were not routinely met by the adaptation of the premises.

There was a range of quality assurance systems to help ensure a good level of quality of care was maintained. However, these systems had not fully ensured that people received a consistent and good quality service that met individual need. Robust day to day management support was not available for staff.

Risks associated with the safety of the environment and equipment were not always identified and managed appropriately.

Although some staff spoke positively of the culture and how they all worked together as a team, feedback from other staff was mixed and indicated that there was a lack of support and a negative culture in the service.

Medicines were managed safely and in accordance with current regulations and guidance. There were systems in place to ensure that medicines had been stored, administered, audited and reviewed appropriately. People were cared for in a clean, hygienic environment and infection control protocols were followed.

People were being supported to make decisions in their best interests. Staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Accidents and incidents were recorded appropriately and steps taken to minimise the risk of similar events happening in the future.

People were happy and relaxed with staff. They said they felt safe and there were sufficient staff to support them. When staff were recruited, their employment history was checked and references obtained. Checks were also undertaken to ensure new staff were safe to work within the care sector. Staff were knowledgeable and trained in safeguarding adults and what action they should take if they suspected abuse was taking place. Staff had a good understanding of equality, diversity and human rights. Staff had received essential training and there were opportunities for additional training specific to the needs of the service, including the care of people with dementia and managing behaviour that may challenge others. Staff had received

supervision meetings with their manager.

People were encouraged and supported to eat and drink well. There was a varied daily choice of meals and people were able to give feedback and have choice in what they ate and drank. Health care was accessible for people and appointments were made for regular check-ups as needed.

People chose how to spend their day and they took part in activities. They enjoyed the activities, which included singing, films, exercises and themed events, such as reminiscence sessions and visits from external entertainers. People were also encouraged to stay in touch with their families and receive visitors.

People felt well looked after, supported and empowered to make their own decisions. We observed friendly and genuine relationships had developed between people and staff. Care plans described people's preferences and needs in relevant areas, including communication, and they were encouraged to be as independent as possible.

People were encouraged to express their views and had completed surveys. They also said they felt listened to and any concerns or issues they raised were addressed. Technology was used to assist people's care provision. Accidents and incidents were monitored to help prevent them happening again.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Potential risks were not identified, appropriately assessed and planned for.

Staff understood their responsibilities in relation to protecting people from harm and abuse. Medicines were managed and administered safely. The service was clean and infection control protocols were followed.

The provider used safe recruitment practices and there were enough skilled and experienced staff to ensure people were safe and cared for.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's individual needs were not met by the adaptation of the premises.

People spoke highly of members of staff and were supported by staff who received appropriate training and supervision.

People were supported to maintain their hydration and nutritional needs. Their health was monitored and staff responded when health needs changed.

Staff had a firm understanding of the Mental Capacity Act 2005 and the service was meeting the requirements of the Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service was caring.

People were involved in the planning of their care and offered choices in relation to their care and treatment.

People were supported by kind and caring staff.

People's privacy and dignity were respected and their independence was promoted.

Is the service responsive?

Good

The service was responsive.

Care plans accurately recorded people's likes, dislikes and preferences, including any future plans they had made. Staff had information that enabled them to provide support in line with people's wishes, including on the best way to communicate with people.

People were supported to take part in meaningful activities. They were supported to maintain relationships with people important to them.

There was a system in place to manage complaints and comments. People felt able to make a complaint and were confident they would be listened to and acted on.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was no registered manager in post. Systems of audit and quality monitoring did not always identify areas that required improvement.

Staff gave mixed feedback in relation to the service being well led. Feedback indicated issues in relation to staff morale, support and a negative culture at the service. Staff were aware of their responsibilities in relation to whistleblowing.

People, relatives and staff spoke highly of the service. Forums were in place to gain feedback from staff and people. Feedback was regularly used to drive improvement. Staff had a good understanding of equality, diversity and human rights.

Chalcraft Hall Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 21 November 2017 and was unannounced. The inspection team consisted of one inspector 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. The expert-by-experience for this inspection was an expert in care for older people.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what they do well and improvements they plan to make. We looked at other information we held about the service. This included previous notifications. Notifications are changes, events or incidents that the service must inform us about.

During the inspection we observed the support that people received in the communal lounge and dining area of the service. Some people could not fully communicate with us due to their condition, however, we spoke with four people, three relatives, two visitors, three care staff, the cook, the deputy manager and the provider. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us.

We spent time looking at records, including four people's care records, four staff files and other records relating to the management of the service, such as policies and procedures, accident/incident recording and audit documentation. We also 'pathway tracked' the care for two people living at the service. This is where we check that the care detailed in individual plans matches the experience of the person receiving care. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Requires Improvement

Is the service safe?

Our findings

People said they felt safe and staff made them feel comfortable. One person told us, "As far as I'm concerned, I've been safe, all my things have been safe". A relative told us, "We are happy that she is safe here". Everybody we spoke with said that they had no concern around safety. However, despite the positive feedback, we identified areas of practice in need of improvement.

Risks associated with the safety of the environment and equipment were not always identified and managed appropriately. Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. Health and safety checks had been undertaken to ensure safe management of utilities, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. People's ability to evacuate the building in the event of a fire had been considered and where required each person had an individual personal evacuation plan. However, no fire drills had taken place for approximately 18 months. Furthermore, the service had no business continuity plan. A business continuity plan instructs staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property. This placed people at risk as staff may not have adequate guidance and knowledge of what to do in an emergency situation. We have identified these as areas of practice that need improvement.

There were further systems to identify risks and protect people from harm. Each person's care plan had a number of risk assessments completed which were specific to their needs, such as mobility, risk of falls and medicines. The assessments outlined the associated hazards and what measures could be taken to reduce or eliminate the risk. We saw safe care practices taking place, such as staff supporting people to mobilise around the service.

There were a number of policies to ensure staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people from abuse. Records confirmed staff had received safeguarding training as part of their essential training and this was refreshed regularly. Staff described different types of abuse and what action they would take if they suspected abuse had taken place. Information relating to safeguarding and what steps should be followed if people witnessed or suspected abuse were displayed around the service for staff and people. Documentation showed that the provider co-operated fully and transparently with relevant stakeholders in respect to any investigations of abuse.

Staffing levels were assessed daily, or when the needs of people changed, to ensure people's safety. We were told agency staff were rarely used and existing staff would be contacted to cover shifts in circumstances such as sickness and annual leave. Feedback from people and staff indicated they felt the service had enough staff and our own observations supported this. One person told us, "They come quickly when I call them". Another person added, "There are enough staff here". A member of staff said, "I personally feel we have enough staff, we work as a team". Another member of staff added, "Now we are up to scratch with staffing, we get agency cover when needed". Documentation in staff files supported this, and helped demonstrate that staff had the right level of skill, experience and knowledge to meet people's individual

needs. Records demonstrated staff were recruited in line with safe practice and equal opportunities protocols. For example, employment histories had been checked, suitable references obtained and appropriate checks undertaken to ensure that potential staff were safe to work within the care sector.

We looked at the management of medicines. Care staff were trained in the administration of medicines. A member of staff described how they completed the medication administration records (MAR). We saw these were accurate. Regular auditing of medicine procedures had taken place, including checks on accurately recording administered medicines as well as temperature checks. This ensured the system for medicine administration worked effectively and any issues could be identified and addressed. We observed a member of staff administering medicines sensitively and appropriately. We saw that they administered medicines to people in a discreet and respectful way and stayed with them until they had taken them safely. Nobody we spoke with expressed any concerns around their medicines. One person told us, "I get my medication when I should. They would check if I've taken my medication". Medicines were stored appropriately and securely and in line with legal requirements. We checked that medicines were ordered appropriately and medicines which were out of date or no longer needed were disposed of safely.

People were cared for in a clean, hygienic environment. During our inspection, we viewed people's rooms, communal areas, bathrooms and toilets. We saw that the service and its equipment were clean and well maintained. We saw that the service had an infection control policy and other related policies in place. People told us that they felt the service was clean. One person said, "It's clean here, they are always cleaning". Another person added, "They service my room daily". Staff told us that Protective Personal Equipment (PPE) such as aprons and gloves had been readily available. We observed that staff used PPE appropriately during our inspection and that it was available for staff to use throughout the service. Hand sanitisers and hand-washing facilities were available, and information was displayed around the service that encouraged hand washing and the correct technique to be used. Additional relevant information was displayed around the service to remind people and staff of their responsibilities in respect to cleanliness and infection control. Infection control training was mandatory for staff, and records we saw supported this. The service had policies, procedures and systems in place for staff to follow, should there be an infection outbreak such as diarrhoea and vomiting. The laundry had appropriate systems and equipment to clean soiled washing, and we saw that any hazardous waste was stored securely and disposed of correctly.

Staff took appropriate action following accidents and incidents to ensure people's safety and this was recorded. We saw specific details and any follow up action to prevent a reoccurrence. Any subsequent action was shared and analysed to look for any trends or patterns. For example, after one incident, the GP was called for a person in order to carry out specific tests, as their behaviour had been out of character.

Requires Improvement

Is the service effective?

Our findings

People told us they received effective care and their individual needs were met. One person told us, "The staff seem well trained". A relative said, "The home worked with [our relative] to provide the care she needs". A further relative added, "Staff are very experienced". However, despite the positive feedback, we identified areas of practice in need of improvement.

People's individual needs were not met by the adaptation of the premises. The service was arranged over two floors, with a lounge, dining room and garden. Other parts of the service were accessible via a lift. A member of staff told us that people rarely used the garden, as the ground was too uneven and potentially dangerous to leave people unattended. At the time of our inspection there were 17 people living at the service. The service had two bathrooms, one on each floor. However, we saw that only one bathroom on the first floor could be used by people to have a bath. This was because the bathroom on the ground floor had not been adapted to enable people to use the bath. A member of staff told us, "It's more difficult taking people upstairs to the bathroom, it would be easier if we could use both". Another member of staff said, "We have one bath for up to 20 residents, it's just not enough". A further member of staff said, "We can't use the downstairs bathroom, it doesn't have the equipment we need in there". Furthermore, two people's care plans stated they required an adapted grab rail to hold onto when having a bath, in order to steady them. Neither bathroom had a grab rail fitted, which placed people at risk of slipping or falling. We also saw that six rooms were fitted with on-suite showers. However, none of these showers could be used by people, as the water temperature could not be regulated to ensure that people were not scalded or showered at an inappropriate temperature. We spoke with staff about this, who told us that the showers had not worked properly for a significant amount of time and people were told they were not available to them. One member of staff told us, "It's a shame they don't work, as one person is quite tall and I know they would prefer their own shower to the bath". Additionally, there were not enough dining chairs available for people to all sit at dining tables for a meal. There were 17 people living at the service, however there were only 15 dining chairs, of which two were wobbly and not well maintained. A member of staff told us, "We have asked to get more chairs, but it hasn't happened".

The above evidence demonstrated that people were placed at risk as the provider had not provided adequate support facilities and amenities, including sufficient available and adapted bathrooms, well maintained shower facilities and adequate seating. This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. 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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the provider was working within the principles of the MCA. Staff had a good understanding of the MCA and the importance of enabling people to make decisions.

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 by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. Applications had been sent to the local authority. Staff understood when an application should be made and the process of submitting one. Care plans reflected people who were under a DoLS with information and guidance for staff to follow. DoLS applications and updates were also discussed at staff meetings to ensure staff were up to date with current information.

Staff undertook an assessment of people's care and support needs before they began using the service. This meant that they could be certain that their needs could be met. The pre-admission assessment were used to develop a more detailed care plan for each person which detailed the person's needs, and included clear guidance for staff to help them understand how people liked and needed their care and support to be provided. Paperwork confirmed people were involved where possible in the formation of an initial care plan and were subsequently asked if they would like to be involved in any care plan reviews.

Staff had received training in looking after people, for example in safeguarding, food hygiene, fire evacuation, health and safety, equality and diversity. Staff completed an induction when they started working at the service and 'shadowed' experienced members of staff until they were assessed as competent to work unsupervised. They also received training specific to peoples' needs, for example around the care of people living with dementia and managing behaviour that may challenge others. Staff told us that training was encouraged and was of good quality. Staff also told us they were able to complete further training specific to the needs of their role, and were kept up to date with best practice guidelines. Feedback from staff confirmed that formal systems of staff development including one to one supervision meetings were in place. Supervision is a system that ensures staff have the necessary support and opportunity to discuss any issues or concerns they may have. Staff had a good understanding of equality and diversity. This was reinforced through training and policies and procedures.

The Equality Act covers the same groups that were protected by existing equality legislation - age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership (in employment only) and pregnancy and maternity. These are now called `protected characteristics´. Nobody living at the service had a protected characteristic, however, staff were knowledgeable of equality, diversity and human rights and people's rights would always be protected.

Staff liaised effectively with other organisations and teams and people received support from specialised healthcare professionals when required, such as GP's, community nurses and social workers. Access was also provided to more specialist services, such as opticians and podiatrists if required. Staff kept records about the healthcare appointments people had attended and implemented the guidance provided by healthcare professionals. One person told us, "The district nurse and the GP have been called in". Staff told us that they knew people well and were able to recognise any changes in peoples' behaviour or condition if they were unwell to ensure they received appropriate support. Staff ensured that when people were referred for treatment that they were aware of what the treatment was and the possible outcomes, so that they were involved in deciding the best course of action for them. A GP was visiting the service on the day of our inspection, and we saw that if people needed to visit a health professional, for example at hospital, then a member of staff would support them. One person told us, "I go out to the dentist and someone goes with me".

People had an initial nutritional assessment completed on admission, and their dietary needs and preferences were recorded. This was to obtain information around any special diets that may be required, and to establish preferences around food. There was a varied menu and people could eat at their preferred

times and were offered alternative food choices depending on their preference. Everybody we asked was aware of the menu choices available. We observed lunch. It was relaxed and people were considerately supported to move to the dining areas or could choose to eat in their bedroom or the lounge. People were encouraged to be independent throughout the meal and staff were available if people required support or wanted extra food or drinks. People ate at their own pace and some stayed at the tables and talked with others, enjoying the company and conversation. All the time staff were checking that people liked their food and offered alternatives if they wished. People were complimentary about the meals served. One person told us, "The meals aren't bad. Sometimes I have something different". A relative added, "[My relative] does like the food here". We saw people were offered drinks and snacks throughout the day, they could have a drink at any time and staff always made them a drink on request. People's weight was regularly monitored, with their permission. Staff had liaised with Speech and Language Team (SALT) to ensure that specialist diets were catered for, such as fork mashable. Nobody at the service required a culturally appropriate diet. However, staff stated that any specific diet would be accommodated should it be required.

Good

Is the service caring?

Our findings

People were supported with kindness and compassion. People told us caring relationships had developed with staff who supported them. Everyone we spoke with thought they were well cared for and treated with respect and dignity, and had their independence promoted. One person told us, "The staff are very friendly, they always speak to me". A relative added, "The staff here are all very good with the residents".

Staff recognised that dignity in care also involved providing people with choice and control. Throughout the inspection, we observed people being given a variety of choices of what they would like to do and where they would like to spend time. People were empowered to make their own decisions. People told us they that they were free to do very much what they wanted throughout the day. They said they could choose what time they got up, when they went to bed and how and where to spend their day. One person told us, "I feel free to move around as I wish". Another person said, "I do feel I can be independent and have choice". Staff were committed to ensuring people remained in control and received support that centred on them as an individual. One member of staff told us, "We offer so many choices, the residents know they can raise anything with us". Another added, "We offer choices around what people want to eat, what they want to wear and what they would like to do".

Throughout the day, there was sociable conversation taking place and staff spoke to people in a friendly and respectful manner, responding promptly to any requests for assistance. We observed staff being caring, attentive and responsive and saw positive interactions and appropriate communication. Staff appeared to enjoy delivering care to people. One person told us, "All the carers are kind and I've not seen any abrasive approach". A relative said, "The carers treat the residents extremely well, kind and compassionate". A member of staff added, "Getting to know people has been great, it's like a home form home for me here being with the residents".

Peoples' equality and diversity was respected. Staff adapted their approach to meet peoples' individualised needs and preferences. There were individual person-centred care plans that documented peoples' preferences and support needs, enabling staff to support people in a personalised way that was specific to their needs and preferences. For example, staff had recognised that to help protect one person's privacy and dignity, they would benefit from specific clothing, which assisted the person to be more comfortable throughout the day, and this had been provided for them. Staff also recognised that people might need additional support to be involved in their care and information was available if people required the assistance of an advocate. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

Staff demonstrated a strong commitment to providing compassionate care. From talking with people and staff, it was clear that they knew people well and had a good understanding of how best to support them. One person told us, "Generally speaking, I know what I need and I get it". We also spoke with staff who gave us examples of people's individual personalities and character traits. They were able to talk about the people they cared for, what time they liked to get up, whether they liked to join in activities and their

preferences in respect of food. Most staff also knew about peoples' families and some of their interests.

People looked comfortable and they were supported to maintain their personal and physical appearance. People were well dressed and wore jewellery, and it was clear that people dressed in their own chosen style. We saw that staff were respectful when talking with people, calling them by their preferred names. Staff were seen to be upholding people's dignity, and we observed them speaking discreetly with people about their care needs, knocking on people's doors and waiting before entering. One person told us, "Staff do treat us with respect, like knocking before coming". Another person said, "I like my own privacy and they give it".

Staff supported people and encouraged them, where they were able, to be as independent as possible. We saw examples of people being encouraged to be independent. For example, people helped to lay tables and fold napkins, which helped them to keep using everyday living skills. One person told us, "I am as independent as I can be here". A relative said, "When [our relative] came in, she didn't walk, but they have got her up and walking with a frame". Care staff informed us that they always prompted people to carry out personal care tasks for themselves, such as brushing their teeth and hair. One member of staff said, "We encourage people to keep their skills going, if they don't use them, they'll lose them. We want them to keep them for as long as possible, but we always help them when they want us to".

Staff encouraged people to maintain relationships with their friends and families and to make new friends with people living in the service. People were introduced to each other and staff supported people to spend time together, in this way genuine friendships were formed within the service. Visitors were able to come to the service at any reasonable time, and could stay as long as they wished. Visitors told us they were welcomed and always offered a drink. One visitor told us, "We can visit anytime". Staff engaged with visitors in a positive way and supported them to join in the communal activities in the lounge, or have private time together.

People's individual beliefs were respected. Staff understood people wanted to maintain links with religious organisations that supported them in maintaining their spiritual beliefs. Discussions with people on individual beliefs were recorded as part of the assessment process. People told us staff would arrange for a priest to visit if they wanted one. One person told us, "We do get visits from the church".

Good

Is the service responsive?

Our findings

People told us they were listened to and the service responded to their needs and concerns. One person told us, "I feel I am getting the care I should".

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify, record, flag, share and meet people's information and communication needs. Nobody at the service who received funding had specific communication needs. However, staff ensured that the communication needs of others who required it were assessed and met. We saw that where required, people's care plans contained details of the best way to communicate with them and staff were aware of these. However, staff were not aware of the AIS and no policy, procedures or training around this had been implemented.

We recommend that the provider obtains information, sources training and implements policies and procedure in relation to compliance with the AIS.

People's needs were assessed and plans of care were developed to meet those needs, in a structured and consistent manner. Care plans contained personal information, which recorded details about people and their lives. This information had been drawn together by the person, their family and staff. A relative told us, "I was involved in the setting up of [my relatives] care plan. When necessary, staff do discuss things with me". Staff told us they knew people well and had a good understanding of their family history, individual personality, interests and preferences, which enabled them to engage effectively and provide meaningful, person centred care. One member of staff told us, "There is good information in the care plans, I have read them". Each section of the care plan was relevant to the person and their needs. Areas covered included; mobility, nutrition, continence and personal care. Information was also clearly documented regarding people's healthcare needs and the support required to meet those needs. Care plans contained detailed information on the person's likes, dislikes and daily routine with clear guidance for staff on how best to support that individual. People were given the opportunity observe their faith and any religious or cultural requirements were recorded in their care plan. A member of staff told us, "Through getting to know one resident, I found out that they were a Jehovah's Witness, so we updated this in their care plan".

Keeping occupied and stimulated can improve the quality of life for a person, including those living with dementia. We saw a varied range of activities on offer, which included singing, quizzes, exercises, films, external entertainers and themed events, such as reminiscence sessions. On the day of the inspection, we saw activities taking place for people. We saw people engaged in a quiz session. There was a lot of laughter and interaction and people appeared to enjoy the stimulation. People told us that they enjoyed the activities. One person told us, "I like music and we do get entertainment". A relative added, "The programme of activities seems good, they have quizzes, music and bingo". The service ensured that people who remained in their rooms and may be at risk of social isolation were included in activities and received social interaction. We saw that staff set aside time to sit with people on a one to one basis in their rooms. One person told us, "There is enough entertainment to occupy me". Staff also supported people to maintain

their hobbies and interests, for example one person had previously worked in an office environment and was supported to assist staff with paperwork in the office. Another person enjoyed writing in a diary and staff encouraged them to continue to do this. Other people enjoyed to play dominos regularly.

Technology was used to support people to receive timely care and support. The service had a call bell system which enabled people to alert staff that they were needed. We saw that people had their call bells within reach and staff responded to them in a reasonable time.

People knew how to make a complaint and told us that they would be comfortable to do so if necessary. They were also confident that any issues raised would be addressed. One person told us, "If I had to complain, I'd go to the manager". The procedure for raising and investigating complaints was available for people, and staff told us they would be happy to support people to make a complaint if required.

Nobody at the service on the day of our inspection was receiving end of life care. However, people's end of life care and future care planning had been discussed and planned for. People were able to remain at the service and be supported until the end of their lives. Records showed that people's wishes and choices, with regard to their care at the end of their life had been documented and reviewed to enable staff to provide the care that people wanted. Staff gave us examples of when they had provided end of life care to people in the past, and told us people's wishes were respected.

Requires Improvement

Is the service well-led?

Our findings

People and relatives spoke highly of the staff and felt the service was well-led. However, comments we received from staff were mixed. Despite the positive feedback, we identified areas of practice in need of improvement.

We found concerns in relation to the management of the service. A registered manager was not 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 and associated Regulations about how the service is run. The service had been without a registered manager for approximately five months. Day to day charge of the service was carried out by the deputy manager. At the time of our inspection, no formal action had been taken to recruit a registered manager. The Health and Social Care Act 2008 requires that as a condition of the provider's registration, that they have a registered manager. We have identified this as an area of practice that needs improvement.

Although the deputy manager undertook several quality assurance audits designed to ensure a good level of quality was maintained, such as medication and infection control. It was seen that the systems of quality assurance had not fully ensured that people received a consistent and good quality service that met individual need. For example, despite this being identified in health and safety audits, fire drills had not gone ahead for approximately 18 months, and known issues in relation to the adaptation and maintenance of the premises had not been rectified. Furthermore, the service had no business continuity plan to guide staff in cases of emergency.

The service did not have formal systems of day to day management support in place for staff. For example, the deputy manager had not received supervision, or a formal one to one meeting for approximately a year since they had been in post. Staff told us that day to day management support was not in place and should they require advice or guidance, they had to contact a registered manager of another service that had no formal links with Chalcraft Hall Care Home. In relation to management support, comments from staff included, "We raise issues, but we are not supported to make improvements", "The [deputy] manager has no support, we have to get support from a manager in another home. There is no formal management support in our home", "Staff are angry and frustrated, the only support we have is to go and ask another home" and, "You can't have a good home if you don't have the support".

The above evidence demonstrated that people were placed at risk as the provider did not have robust systems of management support, or effective systems to monitor and improve the service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have identified this as an area of practice that needs improvement.

We asked staff about the culture of the service, how they communicated and worked together as a team, and whether they felt supported within their roles. The feedback we received was mixed. One member of staff said, "We get on well and work together as a team". A further member of staff added, "I can approach

[deputy manager] with anything, she has an open door policy and listens to us. We all work well together". However, feedback from staff was not always positive about the culture and support of the service. One member of staff told us, "We work well as a team, we have to, as we only have each other. I don't feel supported, so we have to support each other". Another member of staff said, "It would be really good to have a manager" A further member of staff added, "We raise things and just nothing happens, we have to battle to get anything changed, or equipment we need". We were told about systems of communication, such as staff meetings and handovers between shifts, which were thorough and staff discussed matters relating to the previous shift. These meetings were seen an opportunity to discuss and analyse any issues with the service. One member of staff told us, "We communicate well and share information that has happened each day, so we can discuss any issues".

However, the culture of a service directly affects the quality of life of people. A positive culture has the ethos of care built around the individual, and acknowledges the importance of fostering positive relationships between people, relatives and staff as the foundation to quality of life. Staff working as an effective team, improves team performance and will impact positively on the quality of life for people and the wellbeing of staff. The lack of a fully supportive, positive culture and dissatisfaction with the service had impacted on the ability of staff to deliver care to the best of their ability. We have identified the above as an area of practice that needs improvement.

People and relatives spoke highly of the staff, the delivery of care and felt the service was well led. One person told us, "I think it is reasonably well run. They seem to be running this place ok". Another person said, "I've been here a while and the home is very competently run by the manager and her team". A relative added, "I think it's run well here. Since the change in management, things have got so much better. This is a very nice home now". People and staff believed the service provided good care to people and met their needs. One person told us, "The best thing for me it is quite relaxed here". A relative said, "The best thing is [our relative] is safe, she has company here and she is well cared for". A further relative added, "We are delighted with this place and the care [our relative] is getting". Staff told us, "Our staff really care. We love all the residents here, it's like a big family, we know them really well" and, "There is a nice atmosphere, we have a laugh and treat the residents like real people. We have a duty of care, every day is a learning curve, and it's all about the residents".

People were actively involved in developing the service. There were systems and processes followed to consult with people, relatives, staff and healthcare professionals. One person told us, "I do feel involved in the running of this place". Another person said, "I think they would listen to comments from us, they do listen to what we say at meetings". A relative added, "They do hold meetings for us and they seem to listen and do things". Meetings and satisfaction surveys were carried out, providing the staff with a mechanism for monitoring satisfaction with the service provided.

We saw that the service also liaised regularly with the Local Authority, the Dementia In-Reach Service, local GP forums and the Clinical Commissioning Group (CCG) in order to share information and learning around local issues and best practice in care delivery. We saw that information was shared with staff around subjects including nutrition and end of life care. Additionally, the service engaged with the local community and a visit from a local school had been arranged to spend time with people.

Staff knew about whistleblowing and said they would have no hesitation in reporting any concerns they had. They reported that managers would support them to do this in line with the provider's policy. We were told that whistleblowers were protected and viewed in a positive rather than negative light, and staff were willing to disclose concerns about poor practice. The consequence of promoting a culture of openness and honesty provides better protection for people using health and social care services. Staff had a good understanding

of equality, diversity and human rights gained through training and detailed policies and procedures. Feedback from staff indicated that the protection of people's rights was embedded into practice.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The manager had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. The manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.

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 15 HSCA RA Regulations 2014 Premises and equipment The provider had not provided adequate support facilities and amenities, including sufficient available and adapted bathrooms, well maintained shower facilities and adequate seating.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that they had systems and processes to ensure that they were able to meet other requirements in this part of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Regulations 4 to 20A).Systems and processes, including management support, did not robustly assess, monitor and mitigate any risks relating the health, safety and welfare of people using services and others.