C.T.C.H. Limited

Chargrove Lawn

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Chargrove Lawn is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Chargrove Lawn provides accommodation and personal care. The care home accommodates 26 people in one adapted building. At the time of the inspection 22 people were living there.

Chargrove Lawn has recently been refurbished and provides spacious communal areas including a lounge/dining room, two additional smaller lounges, a sun lounge and accessible gardens. People's rooms are individualised and have en suite facilities. They also have access to shared toilets, showers and bathrooms.

This inspection took place on 9 and 10 January 2018. At the last comprehensive inspection in October 2015 the service was rated as Good overall.

At this inspection we found the service remained Good.

There was a registered manager in place who was also registered to manage another of the provider's residential care homes. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People benefited from an improvement agenda for the home which included not only a refurbishment of the environment but also focussing on their wellbeing and offering a more personalised service. An increased range of activities had been offered to people including trips out and meeting with people from other homes owned by the provider. People were supported to develop friendships. People's preferences and lifestyle choices were explored with them and respected.

People's health and wellbeing were promoted. They had access to a range of health care professionals and their changing needs were responded to in a timely fashion to keep them healthy and well. Any risks had been identified and strategies were in place to minimise these, keeping people safe. Staff understood how to identify and report suspected abuse and relatives and people said they felt safe care was provided. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Deprivation of liberty safeguards were applied for where people were restricted of their liberty.

People were supported by staff who had been through a recruitment process which verified their competency and aptitude for the roles they were to perform. Staff had access to training to equip them with the skills to support people. They were supported to develop in their roles with individual meetings, annual

appraisals and staff meetings. People had developed positive relationships with staff and were treated kindly and with dignity and respect.

People's views were sought as part of the quality assurance process to drive through improvements. People, relatives and staff were able to give feedback by a variety of means. Meetings and forums were held, as well as making good use of information technology. A range of quality assurance audits were completed by staff, the registered manager and the provider to monitor and evaluate the quality of service provided.

The registered manager was open and accessible to people, their relatives and staff. Complaints were investigated and responded to with action being taken in response to any lessons learnt. Actions were taken to drive through improvements in response to accidents, incidents and complaints. The management team worked closely with a range of organisations and agencies to keep up to date with current best practice and to improve people's experience of their care and support.

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 remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Chargrove Lawn

Detailed findings

Background to this inspection

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

This inspection took place on 9 and 10 January 2018 and was unannounced. One inspector carried out this inspection.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We reviewed the Provider Information Record (PIR). This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they plan to make. We contacted the commissioners of the service to obtain their views about the care provided to people.

During our inspection we spoke with eight people and five relatives. We spoke with the registered manager, a representative of the provider, deputy manager, the chef and six members of staff. We looked at the care records for four people, including their medicines records. We looked at the recruitment records for four new members of staff, training records and quality assurance systems. We have also used feedback given to the provider as part of their quality assurance processes and from a national website. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home. One person commented, "Staff are always there when needed." Relatives said, "She is happy and safe, that is what is important", "We are reassured she is safe" and "I have no worries about my mother's care and feel safe in the knowledge that her every need will be catered for." Staff had a good understanding of how to keep people safe and their responsibilities to report any concerns. They were confident management would take the appropriate action in response to suspected abuse and said they would use the provider's whistle blowing procedures if they had concerns. Whistle blowing legally protects staff who report any issues of wrongdoing. Staff had access to safeguarding protocols and contact details of organisations to raise concerns with. Safeguarding concerns had been raised when needed with the local safeguarding team and the Care Quality Commission.

People's rights were upheld. Their needs related to their protected characteristics under the Equality Act, for example, age, disability, race or religion, had been discussed with them at the point of admission to assess whether any adjustments needed to be made. Staff spoke about how they tried to promote positive relationships between people preventing harassment and discrimination.

People were supported to stay as safe as possible. Any hazards they faced had been assessed and risk assessments described the strategies in place to minimise these. People's independence, choice and freedom of movement were promoted. For example, one person liked to go out for walks and staff made sure they knew when they were going out and their planned return time. Risk assessments were reviewed each month to make sure any changes had been identified and the appropriate action taken. Accident and incident records were kept and monitored closely to assess if any trends were developing which needed to be addressed. For example, after increasing falls people were referred to their GP, the occupational therapist and/or physiotherapist to reassess their physical health and mobility. Action had been taken and monitored to make sure risks had been managed and people were safe. Where necessary people were supplied with equipment to help them stay safe such as walking aids, high/low beds with mattresses on the floor and hoists.

People who at times became distressed or anxious were helped by staff to manage their emotions and to become calmer. Their care records described what might upset them and the action staff should take. Staff had received guidance and training, in line with current best practice, from health care professionals to understand people's mental health wellbeing and how best to support them. Staff were observed effectively using distraction and diversion, acknowledging people's distress and supporting them to become calmer.

People were supported by sufficient staff to meet their needs. The representative of the provider discussed how dependency levels were monitored. They said the needs of recent new admissions and changes to people's needs would be reviewed and reassessed to make sure staffing levels were appropriate for the current needs of people. Staff spoke about being busy and trying to manage peak times such as meal times, saying "We get on and cope" and "We work well together as a team." Some staff had trained in dual roles and were able to help out with personal care tasks if needed. Recruitment procedures were managed robustly and staff were appointed after all the necessary records had been received and checks had been

completed. There was evidence gaps in employment history were verified and people's character and competency were checked through references and a Disclosure and Barring Service (DBS) check. DBS checks are a way that a provider can make safer recruitment decisions and prevent unsuitable staff from working with vulnerable groups of people. New staff completed an induction programme which included health and safety and safeguarding.

People's medicines were administered and managed satisfactorily. Staff had completed training in the safe management of medicines and were observed administering medicines to confirm their competency. Medicines audits were carried out each week and monthly. Any issues were identified and discussed with staff. Gaps in the medicines administration record (MAR) were checked straight away to make sure medicines had been given. People had their medicines at times to suit them and staff were observed making sure they had been given within the correct time frames. For example, pain relief was prescribed every four hours and they were heard explaining this to the person. Medicines which needed additional security were managed appropriately and were administered by two members of staff. People were supported to manage their own medicines if they wished. They had secure facilities in their rooms. Staff were observed discreetly and sensitively discussing with people their medicines and staying with them until they had taken them. The management team were observed reviewing people's medicines with health care professionals and keeping staff up to date about any changes. People had a transition record which kept up to date information about their medicines which could be shared with other organisations if needed.

People were protected against the risk of infection. Measures were in place to prevent and control the risk of infection. An annual report had been produced in line with the code of practice in the prevention and control of infections. Staff had completed the relevant training and had been provided with personal protective equipment. New records had been put in place which confirmed fire, water systems and legionella checks were monitored in line with current guidance and legislation. Staff had completed food hygiene training and the catering facilities had been awarded the top score of five stars by the food standards agency. Infection control procedures were monitored by the provider.

Action had been taken in response to safeguarding concerns raised at another home owned by the provider. Any lessons which were learnt had been shared and preventative action taken to minimise the risks of similar incidents occurring at Chargrove Lawn. For example, two waking night staff had been employed instead of one waking night staff with one sleep in member of staff. Accidents and incidents were monitored by the representative of the provider ensuring the appropriate action had been taken and risks minimised.

Good

Is the service effective?

Our findings

People's needs and choices were being assessed. People were assessed prior to being admitted to the home. The management team visited people in their homes or hospital and liaised with relatives and social or health care professionals to decide whether they were able to meet their needs. Throughout their stay at the home people's needs continued to be assessed and reviewed in line with evidence based guidance to ensure their care was being delivered effectively. Nationally recognised tools were used to assess areas such as people's activities of daily living, risks to their nutrition and diet and risks to the integrity of their skin.

People's protected characteristics under the Equality Act were promoted. Staff had access to training in Equality and Diversity. People's spiritual, religious, sexual and cultural needs had been identified as part of their initial assessment of need. People's diverse needs were considered and whether any adjustments needed to be made to the delivery of their care. For example, people with sensory disabilities were supported to manage their hearing aids and glasses.

People benefited from the use of technology and equipment to ensure their care was effective and promoted their independence. The management team were using an application on their smart phones to share information with each other, which could then be immediately shared with staff. An electronic touch screen tablet had been set up in the reception area inviting people and their relatives to provide instant feedback to the provider. A television screen in the reception area was also being used to share information and photographs with people. People's independence was promoted through equipment which made use of electronic sensors for example, mats which alerted staff if they had moved and required support. People had access to call-bells in their rooms to request staff to visit them.

People were supported by staff who had access to training and support to develop in their roles. Staff confirmed they had access to a range of training. Staff commented, "The dementia training really made a difference and helped me understand people better" and "There is lots of training." The training needs of staff were closely monitored by the provider's training lead who produced a monthly spread sheet and individual prompts to staff about any training they needed to update. Staff had access to open learning, training delivered by internal trainers and also external courses. Staff had completed training in subjects considered mandatory by the provider such as first aid, fire, moving and handling and food hygiene. In addition they completed training in dementia, end of life and mental health. New staff completed the care certificate and could progress to the diploma in health and social care. A schedule was in place for individual support meetings with staff held every other month. Annual appraisals were arranged to review the performance of staff and their professional development. Staff were also observed carrying out their duties to ensure they had the skills to match their knowledge base. People commented, "Staff are brilliant" and "Staff try their best."

People were encouraged to have a healthy diet. Their dietary needs had been considered and the chef was kept up to date with changes in people's needs. Meals were provided by an external contractor and people said they were happy with the range of meals and the portion sizes. As a result of feedback from people a chicken curry had been added to the menu. People and their relatives had recently been invited to a taster

session to trial new meals. The chef confirmed they were able to provide soft, mashed or fortified diets. They were aware of any allergies and people confirmed these had been considered when offering them a meal choice. The chef had introduced cooked breakfasts and a range of different snacks throughout the day to encourage people to eat. They were aware of who was at risk of malnutrition and provided milkshakes in addition to meals.

People were given choices about their meals. They chose the main meal and were offered vegetables and side dishes at the table giving them an informed choice about what they wished to eat. People were observed being supported to eat their meals. Staff were attentive and people ate their meals at their own pace. Meal times were relaxed and unrushed. Specialist crockery was provided including brightly coloured cups and plates to encourage people living with dementia to eat and drink. A private dining area was available for people and their relatives and visitors. There were plans to also provide a café for people to entertain guests. People said, "The food is very nice", "They never run short, plenty of food" and "It was a lovely meal, I would have it again."

People were supported to stay as healthy and well as possible. A relative commented, "She has gained weight and strength and her health has improved." They benefited from the enhanced services provided by a local surgery, whereby one GP was responsible for visiting each week; this meant that people saw a doctor when they needed to and their medication was reviewed regularly. They had access to a range of health care professionals when needed. Staff worked closely with social and health care professionals to co-ordinate their care and support. Records were kept of any communication and shared with the staff team. Staff were observed liaising with social and health care professionals to ensure people received effective care and support as they moved between services. For example, when being discharged from hospital for a period of short term care at the home.

People benefited from a newly refurbished environment. Communal areas and individual rooms had been upgraded. People told us, "I liked it as soon as I came, it has a lovely family feel" and "I love the new décor." A relative commented that the lighter environment had "really helped people with sight problems". People were able to choose where to spend their time in the spacious lounge/dining room, one of the two smaller lounges, the sun lounge or in their rooms. People's diverse needs had been considered with signage using photographs and large print on a yellow background, making them accessible to people living with dementia and with sensory disabilities. Carpets had been replaced during the refurbishment with most communal areas having a laminated floor which was easier for people to mobilise on. An on-going maintenance plan was in place.

People's capacity to make decisions about all aspects of their day to day care had been considered in line with the Mental Capacity Act 2005 (MCA). The 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's care records highlighted where they had capacity to make decisions about their care and support and when decisions would need to be made in their best interests. There was evidence who had been involved in making decisions in people's best interests for example their relatives and health care professionals. People were observed being given choices about their day to day lives, what to eat and drink, where to spend their time and with whom and what activities to be involved in.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Applications had been made on behalf of people who were being deprived of their liberty or who had restrictions in place. The deputy manager confirmed no one was being deprived of their liberty but appropriate applications had been made in the past.

Good

Is the service caring?

Our findings

People had positive relationships with staff. They were treated with kindness and care. People said, "They will go out of their way to help you. I am very happy here", "Staff are always happy and talkative", and "I am very pleased with it. They treat us nicely and we are able to do what we want to." People were observed spending time with staff, chatting and laughing. Staff had been issued with new contracts of employment which prompted them to be person centred and to focus on people's wellbeing. Staff said this could be difficult at busy times but they were observed, when it was quieter, spending time with people. People's backgrounds and histories had been explored with them. A new life history folder was being put together with them and their families. These illustrated people's histories with pictures, photographs and post cards. The deputy manager said staff would use this to reminisce with people.

People's communication needs had been considered and how these were impacted on by their disabilities and sensory needs. Their care records guided staff about how to communicate with them, such as quietly and slowly or loudly and ensuring they had eye contact. One person commented, "I have a serious difficulty with hearing and am thankful for everybody's patience." A picture book was available to help people identify their needs. People said staff responded to them in a timely fashion, "I am very supported by all the staff." Staff were observed monitoring and responding to call bells during our inspection.

People's culture, disabilities and backgrounds were considered to ensure information was accessible and easily understood. The management team were considering how they could promote better communication within the home. This included the use of paper records using larger print and pictures as well as information technology such as smart phones and electronic screens. People had access to software to make calls anywhere in the world which they could also use visually to see people they were talking with. People had access to Wi-Fi (technology for wireless internet access) within the home so they could use their own electronic devices.

People's diversity was considered. People's protected characteristics were identified in their care records such as their sexuality, religion and disability and their care records prompted staff that they had the "right to participate fully and to have the same relationships as everyone else". Staff respected people's right to family life. Staff gave consideration to their relationships with others and respected their right to privacy. People's preferences for the gender of staff providing their person care had been discussed with them and were respected. People's spiritual and cultural preferences had been discussed and if people could not attend a local place of worship they were able to attend a service held within the home.

People were supported to express their views about their care and support. The provider information record stated, "People are encouraged to play an active part in planning, decision making and offering their views and opinions through the care planning process." Each person met formally every month with a named member of staff (key worker) to talk through their care needs. A record evidenced if any changes were made to their care and support. Relatives confirmed their involvement and said they were kept involved and informed. Where a lasting power of attorney (LPA) was appointed they had the authority to make specific best interests' decisions on behalf of that person, if they were unable to make the decisions for themselves.

There was evidence that LPA's had been included in the decision making process. Information about access to advocates was provided. Advocates help people to express their views, so they can be heard. They can be lay advocates or statutory advocates such as Independent Mental Capacity Advocates (IMCAs).

People were supported with dignity and respect. People had been asked their preferences for how they were addressed such as their full name or their first name. Several people had suggested the use of endearments such as "dear" or "love". Staff had been issued with a postcard promoting the dignity of people. It stated, "I am a person not a condition." This card accompanied their new job descriptions which reflected best practice and promoted innovative ways of working with people. People's independence was promoted and staff were observed encouraging them to stand up and walk independently. Visitors were made to feel welcome and could visit whenever they wished. Protected meal times had been removed to enable relatives to join people at meals. Relatives commented, "Staff are very nice and always makes you welcome" and "Staff are very helpful, they talk with her and she is happy."

Good

Is the service responsive?

Our findings

People's care was individualised reflecting their personal wishes, lifestyle choices and their changing needs. People's care records were discussed with them and their relatives. Each month people chatted with a named member of staff (key worker) about their care and support. Their strengths were recognised and their care records clearly detailed what they could do for themselves and what they needed help with. People's independence was promoted for example, encouraging them to walk with the use of walking frames or sticks and helping themselves to drinks and snacks. When people's needs changed their care records were updated to make sure they received the right care and support. For instance, when a person had an increasing number of falls, they were referred to health care professionals who supplied equipment such as a stand-aid, to help them transfer between their bed and chair with the help of a member of staff. An information sharing folder had been developed to make sure staff were aware of any changes to care plans or people's needs. People commented, "The staff are always helping someone" and "They look after us really well."

People's human rights and their physical, emotional, social and intellectual needs were understood by staff. A new lifestyle profile was being introduced which highlighted their backgrounds, lifestyle preferences and how they communicated. Consideration had been given to whether any adjustments needed to be made to their care and support in light of their cultural, spiritual and sexual needs and their disabilities. People had been supported with personal relationships and staff recognised their need for privacy and personal space. People were supported to attend local churches as well as attending a service held within the home. People living with dementia had access to crockery to encourage them to eat, as well as finger food and signage to guide them around the home. They were also provided with items, such as twiddle muffs (to keep busy hands warm and occupied), which they could interact with.

People had access to a range of activities which enabled them to follow their interests and hobbies. An activities co-ordinator worked alongside staff to provide activities which engaged with people such as quizzes, ball games, music and movement, fitness exercises and arts and crafts. People had enjoyed trips out for afternoon tea, a boat trip, to a musical event and to see a show band. They often met with people who lived in other homes owned by the provider. As a result friendships had developed and a new pen pal scheme had been introduced to keep people in touch. An activities forum had been held and people had suggested other activities they would like to try such as inviting the local women's institute to the home, a knit and natter group and a health and beauty session. Local school children had visited the home to socialise with people, to sing to them and at Christmas brought each person a present. Older children and students also visited as part of national award schemes.

People with sensory loss were supported to manage any equipment they might use. Staff checked people's glasses and hearing aid batteries each morning to ensure they were in working order. Televisions were set to provide subtitles for people with hearing loss. People's care records guided staff about the best way to communicate with people. Staff were observed sitting with people at their level, facing them and using a loud clear voice if needed.

People had information about how to make a complaint. They told us, "I don't have any problems" and "I would talk with staff." Relatives said, "When I raised concerns about the laundry they were dealt with quickly" and "I talk to the manager as issues arise." People could raise concerns using the complaints form or discuss them at the residents meetings held periodically throughout the year. The provider information record stated, "The service has a culture of openness and transparency where apologies are made when things go wrong." Two complaints had been received over 12 months and were thoroughly investigated with evidence that action had been taken to address the concerns, such as providing additional staff training or medication reviews. The registered manager said any learning in response to complaints was shared between all homes owned by the provider.

People's preferences for end of life care had been discussed with them. If they had any particular requests or wishes these had been noted in their care records. Staff liaised closely with health care professionals to make sure people were comfortable and pain free. Accommodation could be provided for relatives if needed and they were made to feel welcome and supported at this time.

Good

Is the service well-led?

Our findings

People benefited from a provider who had a clear vision to improve the quality of care and support provided. The aim of the organisation, as described on their website, was quoted as "to make sure you enjoy the best time possible, and make new memories for you and everyone". Relatives commented, "You couldn't find somewhere better" and "It has really improved over the years." People told us, "It's better than it was" and "It's very good, they look after us really well." Staff said, "It's better than it has been" and "There is still room for improvement." The registered manager said they encouraged staff and people to access them at any time operating an "open door" policy to the office. The provider information record stated, "The service has an open and transparent and responsive culture, this culture is shared with the team." The representative of the provider explained the "whole home" approach whereby all staff were encouraged to be involved in all aspects of the home. They gave an example of how domestic staff raised issues about people's wellbeing with care staff and how staff undertook spontaneous activities.

The registered manager considered one of the major challenges was to manage two care homes and to ensure both homes had management cover and good communication between senior staff teams. Information technology was seen to be working effectively to achieve this. An application on a smart phone kept the registered manager instantly in touch with both services and any information they needed to know, without the need of locating them by landline. They had identified improvements for Chargrove Lawn including to embed activities and encouraging staff to be less "task focused" and more person centred. They had plans to develop a café area as well as implementing a new residents' council.

The registered manager was supported by the provider to carry out their role and responsibilities. They had individual meetings with the representative of the provider to monitor and evaluate the quality of service provided. Action plans were developed and monitored by the provider to make sure any improvements or changes had been implemented. For example, making sure staff had access to individual meetings and their care practice was observed. The registered manager understood his responsibilities to meet the Care Quality Commission's (CQC) requirements and to adhere to health and safety legislation and keep up to date with changes in legislation and best practice. People's personal information was kept confidentially and securely in line with national guidance. Staff said they would be confident raising concerns with the management team and that the appropriate action would be taken in response. Disciplinary procedures were in place which would be used if concerns were raised about the professional conduct of staff. Staff had been issued with new job descriptions which focused on person centred care and the wellbeing of people. A team meeting had been held to discuss these with them.

People, their relatives and staff were asked for their views about the service. There were a variety of ways in which they could provide feedback such as residents' and relatives' meetings, staff meetings, annual surveys, complaints and compliments and external websites. A new residents' council was being set up and six people had offered their services. The provider information record stated this would enable "service users to voice their opinions, give requests and suggestions on how they would like the service to run and perform".

Quality assurance processes were completed by staff, the registered manager and the representative of the provider. Health and safety systems, care planning, staff support and the environment were all regularly monitored. Any actions identified were checked each month to make sure they had been implemented to drive through improvements. For example, removing protected meal times to improve visiting times, moving forward with the refurbishment of the home and increasing the range of activities provided. The representative of the provider said, "We have come a long way, in a short space of time."

Lessons were learnt from accidents, incidents and complaints to make improvements to people's experience of their care. For instance, employing two waking night staff. Staff commented this was "much safer". Information technology had been introduced to enable people, relatives and staff to give instant feedback via an electronic touch screen tablet. The tablet enabled them to give feedback to a national organisation as well as to The Cedar Trust. The national organisation had rated the home as 9.4 out of 10 on its website.

The registered manager described how they and staff worked in partnership with other organisations and agencies. They kept in close contact with social and health care professionals ensuring smooth transitions between services whether people were moving into or out of the home. They sought advice from commissioners and the local authority when needed. The representative of the provider described how the management team would be working towards an admission process which could be offered seven days a week in light of recent requests from commissioners. They were taking part in a county wide project to improve activities for people in care homes. The management team had also liaised with village agents to get people out into the community and to invite people from the community into the home. They were already offering a dining service to one couple living in the community and would offer a bathing service. The local women's institute had been asked to meet with people living in the home and had been offered facilities for their meetings. The registered manager attended a local care home providers association and the representative of the provider had a place on the board. Staff were also involved with a learning exchange network, dementia and activity forums to ensure their knowledge and skills reflected current best practice.