

# The Fremantle Trust

# Chesham Leys

## 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

This inspection took place on 14 and 15 November 2017. It was an unannounced visit to the service.

We previously inspected the service on 31 October, 01 November and 09 November 2016. The service was not meeting all of the requirements of the regulations at that time. We had concerns about fire safety measures and support given to staff. We asked the provider to take action to address this. They sent us an improvement plan which told us about the changes they would make. On this occasion we found improvements had been made to ensure people received safe care that was appropriate to their needs.

Chesham Leys provides nursing care for up to 62 people. Fifty four people were living at the service at the time of our inspection. The service provides nursing care to older people and people with dementia.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

We received positive feedback about the service. Comments from people included "They're a wonderful group of staff here," "I have been living here for two years and I am well cared for" and "The people are brilliant; the standard is high, I can't fault it. The staff and management are excellent." A community professional's feedback included "I can say that Chesham Leys have worked really hard to improve standards."

The service had received many compliments. One included "I would like to take this opportunity to thank everyone at Chesham Leys for all their help in making mum's time in Chesham as comfortable and welcoming as they did. My personal dealings with yourself and your colleagues were always incredibly easy, nothing was ever a bother and any queries dealt with promptly. I loved the relaxed and openness of the home. More importantly was the carers and nursing staff themselves; they treated mum with care and respect."

People were kept safe at the service. This included use of thorough recruitment practices before staff were appointed. Staff knew about safeguarding people from abuse and had undertaken training in this area. Medicines were handled safely to make sure people received them in line with the prescriber's instructions. Equipment had been serviced and was safe to use. The premises were well maintained and fire safety checks were carried out.

People's needs were assessed before they moved to the service. Care plans documented any support needs people had. These had been kept up to date. People received the medical support they required. We did not have any concerns about how people were cared for at end of life but have made a recommendation for best practice to be followed.

The building was clean and tidy; there were no unpleasant odours. Staff wore disposable protective items when they carried out personal care to prevent the spread of infection. We have made a recommendation for the service to follow best practice with workflow in the laundry to reduce the risk of contamination.

Staff received appropriate support to help them develop as professional workers. This included an induction, training and supervision. Staff meetings were held to discuss practice and share ideas.

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. The service had started to look at ways of making information accessible to people who had communication needs. We have made a recommendation for more work to be done in this area to comply with the Accessible Information Standard.

Activities were provided for people to provide stimulation. The service took part in events held between some of the provider's other homes such as baking and gardening competitions.

Management was open and transparent. The registered manager was aware of their responsibilities. They were assisted by a senior team; a new clinical lead had been appointed to manage nursing practice. There were clear visions and values for how the service should operate and staff promoted these. Monitoring and audits took place to assess the quality of people's care. We have made a recommendation about recording any actions from audits and signing these off when completed.

## 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 effective.

People received safe and effective care because improvements had been made to how staff were professionally supported.

People were encouraged to make decisions about their care and day to day lives. Decisions made on behalf of people who lacked capacity were made in their best interests, in accordance with the Mental Capacity Act 2005.

People received the healthcare support they needed to keep healthy and well.

People's nutritional needs were effectively met.

The home worked well with external agencies to ensure people received continuity of care when they moved between services.

Good ●

### Is the service effective?

The service was effective.

People received safe and effective care because improvements had been made to how staff were professionally supported.

People were encouraged to make decisions about their care and day to day lives. Decisions made on behalf of people who lacked capacity were made in their best interests, in accordance with the Mental Capacity Act 2005.

People received the healthcare support they needed to keep healthy and well.

People's nutritional needs were effectively met.

The home worked well with external agencies to ensure people received continuity of care when they moved between services.

Good ●

### Is the service caring?

The service was caring.

Good ●

Staff treated people with dignity and respect and protected their privacy.

People were treated with kindness, affection and compassion.

People were supported by staff who engaged with them well and took an interest in their well-being.

### **Is the service responsive?**

**Good** ●

The service was responsive.

People's preferences for their care were supported by staff and through care planning.

There were procedures for making compliments and complaints about the service.

The service responded appropriately if people had accidents or their needs changed, to help ensure they remained independent.

People were supported to take part in activities to increase their stimulation.

### **Is the service well-led?**

**Good** ●

The service was well-led.

People's needs were appropriately met because the service had an experienced and skilled registered manager to provide effective leadership and support.

There were clear visions and values at the service which staff promoted in how they supported people.

The provider monitored the service to make sure it met people's needs safely and effectively.

People were cared for in a service which was open and transparent when things went wrong.

The registered manager knew how to report any serious occurrences or incidents to the Care Quality Commission. This meant we could see what action they had taken in response to these events, to protect people from the risk of harm.

# Chesham Leys

## **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 14 and 15 November 2017 and was unannounced.

On the first day, the inspection was carried out by one inspector, a specialist advisor whose area of expertise was nursing care 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. On the second day the inspection was carried out by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications and any other information we had received since the last inspection. A notification is information about important events which the service is required to send us by law.

We contacted community professionals, for example, the local authority and health service commissioners of the service and the safeguarding team, to seek their views about people's care.

We spoke with the registered manager and ten staff members. This included nurses, care workers, housekeeping staff, the chef and activities staff. We met with the regional manager for the service on the second day, to provide feedback on the inspection visit.

We checked some of the required records. These included ten people's care plans, medicines records in two parts of the home, four staff recruitment files, four staff development files and the training matrix for all staff. We looked at a range of other records which included accident and incident reports, monitoring records and records of checks such as gas, electrical and water safety.

We spoke with twelve people who live at the home and two visitors. Some people were unable to tell us about their experiences of living at Chesham Leys because of their dementia. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

# Is the service safe?

## Our findings

When we inspected the service in October and November last year, we had concerns about safety. This was because fire safety checks were not always carried out regularly and in line with the provider's policies. We asked the provider to take action to address this.

On this occasion we found improvements had been made. The fire log showed regular tests and checks had been carried out. These included testing of call bells, the means of escape and emergency lighting. Drills had been carried out on three occasions since the last inspection. We mentioned to the registered manager there was no record of how each fire drill was conducted, how long it took and any lessons learned. Since the inspection, the provider has shown us the new procedure they will be rolling out in all their services, to address this point.

People we spoke with told us they felt safe. Comments included "I like living here. I feel relaxed and safe," "I feel safe and I'm happy to be here" and "I feel safe and have no complaints."

The service had systems and processes for safeguarding people from abuse. These provided guidance for staff on the processes to follow if they suspected or were aware of any incidents of abuse. Staff had also undertaken training to be able to recognise and respond to signs of abuse. Staff were able to give detailed information about what abuse was and how to respond appropriately. For example, one member of staff said "I would report the incident and I would make sure to record it in the care file and on an incident report, tell the manager who reports to the local authority safeguarding team."

Risks were managed well to keep people safe. We saw risk assessments had been written and were included in each person's care plan. These included people's likelihood of developing pressure damage and supporting people with moving and handling, as examples. Where risks were identified, the home had put measures in place to reduce these. For example, two staff assisted people who required use of equipment to help them re-position. Staff undertook training in moving and handling each year to ensure they supported people safely.

People's personal records were kept secure. They were accessible to staff when they needed to refer to them. Records were accurate and legible.

We spoke with the registered manager about behaviour the service found challenging. They said there was very little behaviour of this type. We looked at the care plan of one person who had a behavioural support plan in place. This advised staff of the same gender to provide support to prevent the behaviour. There was appropriate involvement of community mental health services.

The building had been well maintained. It was built to modern specifications around three years ago. We saw there were certificates to confirm it complied with gas and electrical safety standards. Water had been tested to check for the presence of harmful bacteria such as Legionella. No traces had been found. Equipment to assist people with moving had been serviced and was safe to use.

We saw emergency evacuation plans had been written for each person. These documented the support and any equipment people needed in the event of emergency situations. Staff had been trained in fire safety awareness and first aid to be able to respond appropriately.

Staffing rotas showed appropriate personnel were deployed to meet people's needs. This included nurses, care workers, housekeeping and catering staff. Although staff were busy, they had time to chat to people and ask how they were. We noted staff managed busy times of the day well to ensure people's needs were met, for example, at meal times. Staff supported people to go to activities and have their hair done in the salon on the ground floor.

People were supported by staff who had been thoroughly recruited. The records we checked showed the service used robust recruitment processes to ensure people were supported by staff with the right skills and attributes. Each recruitment file contained evidence of all required documents. This included a check for criminal convictions, written references and proof of identification. A check was made to ensure nurses were registered with the Nursing and Midwifery Council. Staff usually only started work after all checks and clearances had been received back and were satisfactory. We saw a risk assessment was in place where a second reference had been awaited. This made clear the member of staff could not work alone or unsupervised until this had been received.

People's medicines were managed safely. There were medicines procedures to provide guidance for staff on best practice. Staff handling medicines had received training on safe practice and had been assessed before they were permitted to administer medicines alone. People told us they received their medicines when they needed them. There was clear guidance on the administration of covert administration with the involvement of the multi-disciplinary team and with the family. Covert administration is when medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example in food or in a drink. A protocol was in place in the care record. We saw staff maintained appropriate records to show when medicines had been given to people. Medicines which required cool storage were kept refrigerated. Temperature checks were made to ensure medicines fridges operated effectively.

Individual protocols were in place where medicines were prescribed to be given 'only when needed' or where they were to be used only under specific circumstances. The protocols gave administration guidance to inform staff about when these medicines should and should not be given. This ensured people were given their medicines in a safe and consistent way.

Medicines which required additional controls because of their potential for abuse (controlled drugs) were stored appropriately within the home. When a controlled drug was administered, the records showed the signature of the person who administered the medicine and a witness signature.

We made a recommendation at the last inspection for staff to record when they had applied creams and other topical preparations. We found this was now being done.

Accidents and incidents were recorded appropriately at the home. These showed staff had taken appropriate action in response to accidents, such as when people fell. There was a system in place for the reporting of incidents and accidents. The CQC had been appropriately informed of any reportable incidents as required under the Health and Social Care Act 2008.

The registered manager took action where staff had not provided safe care for people. For example, where errors had occurred. Records were kept of meetings held with staff following incidents of this nature, to

determine what had happened and to prevent recurrence. Disciplinary proceedings were used where necessary.

People were protected from the risk of infection. Staff who handled food, including care workers, undertook food hygiene training. The home had been awarded an overall food standards hygiene rating of five, which is the highest rating for very good practice. There was guidance on best practice for the control of infection. Staff wore single use disposable aprons and gloves when they supported people with personal care. Aprons were also put on when staff supported people at mealtimes.

The building was kept clean; there were no unpleasant odours. Sluice rooms were kept tidy and in good order. We noted a faulty lock on one sluice room door. This had been reported to the maintenance team. The laundry was in good order. All washing was stored in skips or baskets, soiled items were bagged and washed separately to prevent cross infection. The laundry had been designed with two doors, one the entrance and one the exit. There was no signage to show which way staff needed to go in or out to make sure a one way system was used. One way movement in the laundry helps to ensure soiled items do not come into contact with clean items.

We recommend signage is used to make the entrance and exit clear in the laundry, to prevent the risk of cross infection.

People were kept safe as the service made sure it followed good practice when things went wrong. For example, there was learning from investigations. Minutes of staff meetings showed staff had been informed of a fatality in another care home after a resident had swallowed a disposable glove. Staff had been reminded to keep all gloves locked away to prevent this happening at Chesham Leys. We saw they did this. The provider kept the home abreast of national safety alerts, such as recalls to equipment, to make sure people were safe.

# Is the service effective?

## Our findings

When we inspected the service in October and November last year, we had concerns about staff support. This was because staff had not consistently received appropriate support and professional development. We asked the provider to take action to address this.

On this occasion we found improvements had been made. We found probationary assessments had been completed for new staff. These provided a formal assessment of their performance and learning before staff were confirmed in post. We saw staff followed a structured induction. They were then enrolled onto the nationally-recognised Care Certificate. The Care Certificate is an identified set of standards that health and social care workers need to demonstrate in their work. They include privacy and dignity, equality and diversity, duty of care and working in a person-centred way. A clinical induction had been produced since the last inspection and had been undertaken by nursing staff. This ensured people were supported in a safe and consistent way.

People were cared for by staff who received appropriate training. Staff undertook various courses. These included safeguarding, moving and handling, fire safety and infection control. There were some courses which needed to be completed or updated for some staff. The registered manager had a plan in place to address this, with dates booked for all relevant staff.

Staff could undertake higher level courses if they wished. For example, two staff had completed Business and Technology Education Council (BTEC) awards in dementia. A further member of staff was undertaking the BTEC award at the time of the inspection; two other staff had enrolled to start it in January 2018.

Staff received supervision from their line managers. Appraisals were also undertaken to look at individual development needs. The registered manager had completed over half of the staff team's appraisals for this year so far.

People's needs had been thoroughly assessed before they received support. Assessments included general health, medicines, hearing and vision, dietary needs, communication, sleep, continence and mental health. The assessments we read took into account equality and diversity needs such as those which related to gender, sexuality, disability and culture.

Information about people's health and well-being was effectively communicated. Staff maintained daily notes to record how people had been. These were written for each shift. Handovers took place between shifts to make sure important information was shared and to provide continuity of care.

People were supported with their nutritional needs. Care plans identified any support people needed and risks associated with eating and drinking. For example, choking. The appropriate consistency of food was provided where people had swallowing difficulties. People's weight was monitored. They were referred to speech and language therapists or dietitians where necessary.

The home's chef was made aware of people's nutritional needs before they moved into the home. They were kept advised of anyone who was at risk of developing malnutrition. Food was fortified with additional high calorie ingredients such as butter and cream. High calorie foods were also provided in between meals, such as crisps and other savoury snacks.

We saw staff provided support to people who needed assistance at mealtimes. This was done in a gentle and unrushed way to help people enjoy their meals. Fresh fruit was available in dining rooms. We saw people were offered drinks and snacks regularly throughout the day. People told us they enjoyed the food. One person told us "I can make requests for meals that I like and it would be put on the menu, so I asked for scampi and chips because it's my favourite." Other people commented "The meals here are nice. The portions are a bit big for me but I do have a small appetite," "I enjoy the food" and "The food is lovely."

We made a recommendation at the last inspection for improvements to be made to fluid monitoring records so that these were used more effectively. On this occasion we found improvements had been made.

People were supported with their healthcare needs. Care plans identified any support people needed to keep them healthy and well. Staff referred people to their GP and other healthcare professionals when necessary. Records were kept of the outcome of these visits so that any actions or follow up were noted.

Staff worked together within the service and with external agencies to provide effective care. Staff told us there was good teamwork. A GP had complimented the service on the appointment of the clinical lead for the home and felt they worked well together. Staff told us about the information they provided when people needed to go into hospital. This was usually following emergencies after an ambulance was called. Staff copied the front sections of the person's care plan which included details of their next of kin, GP, religion and preferred name, together with their preferred routine of how they liked to be supported. A copy of their medicine chart was also taken. This helped to ensure people received effective and consistent care when they moved between services.

The design of the building took into account the needs of people with a range of disabilities. This ensured the layout and equipment that had been provided helped people to remain independent. For example, doorways and corridors were wide enough to accommodate wheelchairs and bathrooms and bedrooms had enough space for manoeuvring hoists and other equipment. There was a passenger lift between floors. Sensory nodules had been fitted to grab rails in corridors, to assist people with visual impairments. There was level flooring throughout the building and around the garden, to enable people to move around safely. There were sufficient spaces for activities to take place and for people to see visitors, other than in their rooms. This included a café area near the entrance and quiet areas with seating around the building. There was signage to show where toilets, bathrooms and exits were. People's names were on their doors to help them identify their bedrooms. Room numbers and pictures were also used.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The service had made appropriate referrals to the local authority and was waiting for some decisions to be made. There were no conditions attached to authorisations thus far. One member of staff told us their understanding of DoLS. They said "We have regular training but what it means to me is that everyone has capacity to make important decisions. When someone comes to a nursing home, if there is any question of deprivation of liberty a best interest and mental capacity assessment has to be made." They added "The clinical lead or manager do these referrals."

## Is the service caring?

### Our findings

People were treated with kindness, respect and compassion. We read several compliments from relatives about standards of care. A relative wrote "Thank you for looking after mum and supporting our family so well. She couldn't have been in a better place, so friendly, caring and personal." One person told us "I like staff, they are kind... they don't mind that I might press the call bell in the middle of the night. I don't feel as if I am being a nuisance." Other people's comments included "I have been living here for two years and I am well cared for," "I like staff because they are really friendly" and "They are very good here, staff are great." The family of a deceased resident had written to the service to express their thanks. They commented "(Name of staff) is a credit to Chesham Leys and I know how kind she was to mum. She made the transition all the more easier and made me feel confident that mum was in caring hands. I felt (name of staff) always had mum's best interests at heart. It was always lovely to see her and have a chat whenever I popped in."

People told us staff were respectful towards them and treated them with dignity. We saw people had been supported to look well presented; care was taken of their clothes. All personal care was carried out behind closed doors to protect privacy. People had single bedrooms and en-suite bathrooms which contributed to promotion of their privacy and dignity.

People were supported to express their views about their care. Where they were unable to do this for themselves, their relatives or advocates were involved. We saw evidence of this in the care plan files we looked at. Reviews varied from three to six months and were signed by those present at the meeting. One person told us "I attend meetings about the care I receive here with my family. I can't remember how regular they are and my family ask all the questions."

People made everyday decisions such as what to eat and drink, whether to join in activities and what they wanted to wear.

We asked if residents' meetings or other forums were held to share information and seek people's views. The registered manager told us there had not been any residents' meetings since 2016. They were unable to find any records of other senior staff at the home holding meetings of this nature. They said they often received feedback from people and recorded this in the complaints and compliments log. The registered manager told us they planned to have meetings for each floor of the building involving the assistant managers and chef. We would expect to see improvement in this area by the time of the next inspection.

A consultation meeting was held in June this year which families were invited to. The trustees for the service were present, to explain their roles, as well as the senior staff team. The minutes showed a range of topics had been discussed. These included updates on making improvements at the service, informing people about recruitment and included forthcoming events. Relatives had been able to give feedback and make suggestions about the service.

We observed staff engaged well with people. For example, we heard staff laughed with people and joked with them. We saw one person was sitting alone. A member of staff asked them if they were alright; they said

they were. The member of staff then started to sing to the person. They responded by smiling and put their hand on the arm of the member of staff and sang with them.

At the end, the staff member thanked the person and continued with their work. Later the staff member told us that before they started working at Chesham Leys they had never heard of the song, which they learned from the residents. They said they enjoyed singing with this person nearly everyday.

People's visitors were free to see them as they wished. One person told us "My son and daughter visit every week and are always made to feel welcomed." Visitors could make themselves a drink in the café area and help themselves to biscuits and freshly baked cakes.

People were supported to be independent. The building had been fitted with equipment and adaptations to help people manage as much for themselves as possible. People had walking aids where necessary. We saw one person go out for a walk. They were able to access the key pad on the front door unaided to exit the building.

Staff respected people's confidentiality. There was a policy on confidentiality to provide staff with guidance. A member of staff asked who we were when we asked for a specific person's care plan. They had come on duty after we were shown around and introduced to staff so they had not met us. They were rightly cautious of the request to look at personal information.

The provider had instigated a 'wishes and dreams' initiative. We heard one person from Chesham Leys had been successfully nominated for this. Work was being undertaken to support them to fly in a Spitfire or similar defence aircraft, to relive their RAF experiences.

People's birthdays were celebrated at the home. Plans were being made to mark the 100th birthday of one person in the coming weeks.

## Is the service responsive?

### Our findings

People received care which was responsive to their needs. Care plans took into account people's preferences for how they wished to be supported. People's preferred form of address was noted and referred to by staff. People's wishes of who they would like contacted if they became unwell were also documented. There were sections in care plans about supporting people with areas such as their health, dressing, washing, bathing and mobility. People's cultural and religious needs were taken into consideration as well as any support they needed to manage physical disabilities and mental health conditions. Care plans had been kept under review, to make sure they reflected people's current circumstances.

Staff had an understanding about person-centred care. One member of staff said person-centred care was when you "Think about yourself. I can wear what I want to, eat what I want, the same applies to our residents. The resident is in the centre, you have to consider their needs, wants, choices." Another member of staff explained that people "Have different care needs and you have to give care the way they want it."

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The registered manager was aware of this standard and some work had started at the home to make information more accessible. For example, menus were being produced in picture format to help people make choices.

We recommend further work is undertaken to make sure people have access to information about their care and treatment.

Staff were responsive to people's needs. Some of the staff we spoke with mentioned they were aware of what could cause a change in behaviour, especially for people who had dementia. For example, they said the person could have an infection somewhere. One member of staff said that they "Would have to report to the nurse," another said they would report it and then said if it was a result of a urinary tract infection they would "Test the urine, send a specimen off." All the staff said they would document any changes or concerns in people's notes. One of the staff said "We need to be aware of any potential issues by reading the resident's care plan."

The service provided end of life care. There was no one at end of life at the time of our inspection. The service had received thank you cards from the families of deceased residents. One card included "Thank you for all the wonderful care (name of person) had...in Chesham Leys. All the staff should have a gold star."

There were sections in care plans to document people's wishes about how they wanted to be supported with end of life care. We looked at two examples of these. Neither had been completed fully, so the person's wishes were not appropriately recorded. We spoke with the registered manager about specialist support. They told us they did not have links with specialist palliative nurses or the local hospice. We also noted training on end of life care was not provided for staff.

We recommend the service establishes links with the local hospice and palliative care team and provides training for staff on end of life care. Further work should be undertaken on making sure people's wishes are fully recorded about how they want to be supported at end of life.

Anticipatory medicines were available when people reached end of life. Anticipatory medicines are those medicines that are prescribed for use on an 'as required' basis to manage common symptoms that can occur at the end of life. For example, for management of pain or breathlessness, nausea and sedation.

People were supported to develop and maintain relationships with those who were important to them. For example, the provider had set up a social media tool which people could use with their smartphones. This enabled friends and relatives to send things such as photographs to the service, to pass on to people. The service had free wireless connection for people to use the Internet. Events were held between the provider's services. For example, a Bake Off competition was held and a Fremantle in Bloom gardening competition. A Christmas get together with a meal out was planned in a few weeks' time. One person told us they really enjoyed these events and said "It's really important to get together with other services and meet up with friends." There was also a regional magazine to let people know what was going on with individual services.

The service supported people to take part in social activities. People told us they enjoyed the activities. One person commented "There have been three activities organisers since I've been here and this one's the best." Another person told us "It cheers me up to go to the daily activities." Other comments included "I like the activities. I have asked for CDs and if they haven't got it they will order it. I always get what I ask for" and "I like the music sessions."

Notices were displayed around the building to inform people what activities were on offer. This included zumba exercises, weekly church services, visiting singers and entertainers, knit and natter and music and movement. Quizzes and reminiscence were also provided. Petting animals visited the home as well as a Pets as Therapy dog.

Flower arranging and crafts were also undertaken; we saw people making craft cup cakes when we visited. One person involved in making the cup cakes described the activity group as "The Wonderful Club."

We saw people made the Christmas cakes for the service as well as an extra one for a baking competition between the homes. People really enjoyed making the cakes. All were given the opportunity to mix and stir the ingredients together, and to taste it at the end. There was chat about Christmas in days gone by and laughter and singing whilst this took place.

Some people said they would like more trips out. The registered manager told us transport was limited for people with disabilities but they had managed to arrange a couple of trips to the pantomime for the weeks ahead.

There were procedures for making compliments and complaints about the service. Booklets were available in the foyer to advise people how they could provide feedback about the service, whether this was a complaint, a compliment or a suggestion. One person told us "If I had any problems or concerns I would be happy to speak to staff."

There had been few complaints at the service; three in the past year compared to numerous compliments. We looked at how two complaints had been handled. In each case the complaint had been investigated and a written response was sent to the person. Actions were taken to remedy matters, where appropriate.

## Is the service well-led?

### Our findings

People received care in a service which was well-led. This enabled them to receive safe, effective and co-ordinated care.

The service had an experienced registered manager. We received positive feedback about how they managed the service. One person told us "The people are brilliant; the standard is high, I can't fault it. The staff and management are excellent." Another person said "Its lovely here, the care here is great." A community professional told us "The manager (name) seems committed to the role and has good support from her team." We read a compliment from a relative which included "I just wanted to say a very big thank you for all the help and support you gave me...you were so professional and calm, as always. At that time it was such a relief for me to know (family member) was going to such a lovely place...All the carers were so kind to her and it was lovely to see her smiling again after the months we spent struggling at home."

Another compliment included "I would like to take this opportunity to thank everyone at Chesham Leys for all their help in making mum's time in Chesham as comfortable and welcoming as they did. My personal dealings with yourself and your colleagues were always incredibly easy, nothing was ever a bother and any queries dealt with promptly. I loved the relaxed and openness of the home. More importantly was the carers and nursing staff themselves; they treated mum with care and respect."

We observed staff, visitors and people who used the service were comfortable approaching the registered manager and other managers to ask for advice, pass on information or just have a chat.

Providers and registered managers are required to notify us of certain incidents which have occurred during, or as a result of, the provision of care and support to people. There are required timescales for making these notifications. The registered manager had informed us about relevant incidents and from these we were able to see appropriate actions had been taken.

Providers are required to comply with the duty of candour statutory requirement. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to registered persons when they are carrying on a regulated activity. The registered manager was familiar with this requirement and was able to explain their legal obligations in the duty of candour process. They showed us an example of a written response they had sent following an incident which met the duty of candour threshold; this contained all the necessary information.

Staff were supported through supervision, training and staff meetings to meet the needs of people they cared for. They worked well together. One member of staff told us "If I have a problem I discuss it with colleagues and with the manager, who is very approachable." They added "Teamwork is brilliant and if I

have a problem with a resident I can call on my colleagues." Another member of staff said "It's different working here from the hospital, but in a nice way. There is lots to learn and we are all supported to make decisions." A further member of staff commented "I feel supported by others" and "The manager is very approachable; I love coming to work."

There was a provider incentive scheme to thank staff who picked up additional shifts to help cover the rotas. A ticket was awarded for each shift they covered. They then had the chance to enter in a draw which had cash prizes. There was a further draw with a jackpot of £5000 they could be entered into.

There were clear visions and values at the service. These were displayed in the foyer and included "Celebrate the uniqueness in everyone" and "Put care and kindness at the heart of all we do." Our observations of care and feedback the home received from families showed these values were being met.

The registered manager ensured the service continually improved. They told us about changes they had made in the past year. These included recruiting more nurses to fill vacant posts and ensuring care plans were more thorough. The deputy manager had recently started the "My Home Life" project. This is a national project that promotes quality of life and delivers positive change in care homes for older people. The registered manager was intending to start it in the new year.

There was learning from incidents and complaints to improve people's care. For example, we asked what action had been taken after a member of staff carried out a procedure against a person's wishes. As well as carrying out disciplinary procedures, the registered manager had ensured since then that the staff handover record contained relevant information to prevent this happening again. Additionally, a coloured sticker had been put on the front of relevant care plan files to act as a reminder for staff.

Staff knew what to do if they had any concerns about people's care and treatment. Staff were advised of how to raise whistleblowing concerns during their training on safeguarding people from abuse. Whistleblowing is raising concerns about wrong-doing in the workplace. There was also a poster with the contact details for the provider and external organisations if staff needed to report concerns. A staff member told us "Whistleblowing is if you suspect something wrong, you must report to your supervisor, your manager, safeguarding team or CQC."

People's care was monitored by the registered manager and senior managers within The Fremantle Trust. A full audit had been carried out in September this year by an external company. It made several recommendations to improve people's care such as improving meal times, recording the registered manager's daily walk around the building and observing activities and how staff communicated with people. We noted the action plan the registered manager had put in place in response to this did not contain many of the points raised for attention. They said this was because some points were already in place at the time of the audit and other points had already been addressed. We noted on reading the report in full after the visit that the auditor had recommended work be done to improve the home's action plan and outcomes of the audit. This included validating outcomes and signing them off when completed. We were unable to see this had been done from the action plan we were shown when at the service. We recommend this is addressed to ensure ideas to improve the service do not become forgotten.

The service worked with other organisations to ensure people received effective and continuous care. For example, the local authority safeguarding team, GPs and tissue viability nurses.

People's records were well maintained at the service. All personal and confidential records were kept locked away when not in use. Staff had access to a range of policies and procedures which were available in the

duty manager's office as well as on line. These provided staff with up to date guidance about best practice.

We found there were good communication systems at the service. Staff and managers shared information in a variety of ways, such as face to face, during handovers between shifts and in team meetings.