Chetwynd House Care Home Limited

Chetwynd House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

About the service
Chetwynd House Care home is a residential care home providing personal care to 67 people aged 65 and over at the time of the inspection, some of whom were living with dementia. The service can support up to 75 people in a single purpose-built home.

People's experience of using this service and what we found

Medicines were managed safely, and people received their prescribed medicines on time. Risks were assessed and risk reduction measures were in place. The provider, manager and staff worked to improve the quality of care people received. Infection control measures in place protected people from risk of harm. Staff were recruited and inducted safely and when issues were found with staff performance the manager and provider acted. People told us they felt supported safely by kind staff. Staff completed safeguarding training and knew what action to take to protect people from abuse.

Quality assurance systems were in place to highlight any shortfalls in the quality of care, new monitoring systems had been introduced following incidents to make further improvements. Lessons had been learnt following incidents and the provider communicated to people and their loved ones when things went wrong. People, relatives and staff told us they felt supported by the management team.

Action was taken when people and staff reported concerns. Staff worked with other health and social care professionals and specialist advice had been sought and followed when needed.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 7 September 2019)

Why we inspected
We received concerns in relation to the management of pressure area care, medicines and falls, we undertook a focused inspection to review these risks. This report only covers our findings in relation to the key questions of safe and well-led only. We have found evidence that the provider had made improvements following incidents to protect people from harm. Please see the safe and well-led sections of this full report.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection. The overall rating for the service has remained the same. This is based on the findings at this inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Chetwynd House Care Home on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Details are in our safe findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-led findings below.

Chetwynd House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by one inspector and two Experts 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.

Service and service type
Chetwynd House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a registered manager registered with the Care Quality Commission, however there was a new manager in place who had begun the registration process. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to

send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with eight people who used the service and ten relatives about their experience of the care provided. We spoke with eleven members of staff including the manager, senior care worker, care workers, housekeeper, chef and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including quality assurances records were reviewed.

After our inspection site visit, we attempted to contact a further eight staff to ask about their experience of working at the service. We reviewed further records this included, staff training information, staff rotas and policies.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were safe and protected from avoidable harm.

Staffing and recruitment
- People told us they felt safe living at the home by staff who cared about them, "I feel safe living here, the staff are all very nice and we have a laugh".
- Staff were deployed safely in order to meet people's needs. People told us calls bell were answered quickly but that sometimes they waited for care due to waiting for moving and handling equipment to become free. We fed this back to the manager who informed us they would look at the moving and handling equipment available and source more if required.
- Staff were recruited safely. Recruitment checks were carried out to ensure all staff were suitable to work at the home.
- Agency staff in use had been inducted safely into the service in order to care for people safely.

Using medicines safely
- Medicines were managed safely.
- Staff received training in the safe administration of medicines, however we found that not all staff had received a yearly update, this was addressed, and action was taken immediately by the manager.
- Medicine records documented how people liked to take their medicines and how staff should support them. Medicines were stored safely and administered in line with best practice guidance.
- Medicine audits addressed issues found and we found action had been taken to mitigate risk associated with medicines.

Systems and processes to safeguard people from the risk of abuse
- People were protected from the risk of abuse.
- Staff undertook safeguarding training and knew who to report concerns to both internally and to externally.
- Following recent safeguarding concerns the provider and manager took appropriate action to address these concerns and protect people from risk of abuse. New monitoring processes had been introduced in order to highlight any areas of concern.
- Staff told us, "I have been well supported by the manager to raise concerns in order to protect people from any harm".

Assessing risk, safety monitoring and management
- Risks were assessed, managed and monitored.
- Safety monitoring had highlighted risks, actions and risk reduction measures were in place to reduce these risks.

● Risk associated with people's pressure area care had been fully assessed and monitored. Where a person was at risk detailed records were in place.
● Peoples individual care records accurately reflected their needs and were person centred. All staff including agency staff had access to care plans. Staff told us, "We have a very person-centred approach and know how to deliver care safely for each person".

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Learning lessons when things go wrong
● Lessons were learnt, and action taken following incidents
● The service identified learning from individual incidents and had implemented new processes to mitigate risk. For example, following incidents involving people who display behaviours that may challenge, individual care plans were reviewed, and an action plan created by the providers specialist in order to reduce repeated incidents.
● The provider utilised specialist support and actions were in place to prevent further incidents occurring. The service worked with health and social care professionals to learn from the incidents and improve the quality of care people received.

Good

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People were supported in a caring manner by staff who knew them well.
- People's outcomes had improved as a result of the changes introduced. For example, there had been a significant decrease in the number of falls.
- The manager and staff were passionate about delivering high-quality person-centred care. Staff told us, "The people are the reason staff work here, nothing is too much for any staff member day or night, we deliver person centred care. Chetwynd is not just a workplace for us, it's a family which I am very proud to be a part of".

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider and manager understood their responsibility to be open and honest with people and acted appropriately when things went wrong.
- Records we reviewed evidenced that incidents were communicated to relatives and advocates.
- People told us the new manager and provider had been open and honest following incidents. For example, one relative told us, "My relative had a fall and they called me straightaway, since then they have put a sensor mat next to the bed. I have every confidence in them".

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Quality assurance audits were carried out and had identified potential risks. Action had been taken to reduce those risks. For example, Investigations into safeguarding incidents had been strengthened in order to drive service improvement.
- The manager understood regulatory requirements. They were aware of their responsibility to notify CQC of certain incidents. Our records evidenced that we received notifications appropriately.
- Daily meetings with staff had been introduced to highlight any quality or safety issues.
- The provider's senior management team were supporting the home and new manager to embed the changes being made.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People told us they were involved in the running of the service. The 'residents board' met monthly and

discussed changes they would like. We spoke to a person on the board who felt they made a real difference to the running of the home, they told us, "If we need something changing, it happens, nothing is too much trouble for the team here".

● People and their families were involved in planning the care they received. A relative told us, "I was involved in drawing the care plan up and we have started to look at other areas more recently".

● Staff were encouraged to voice their ideas and raise concerns through supervisions and daily meetings.

Working in partnership with others

● The service referred to health and social care professionals and implemented their advice into care plans on order to improve outcomes for people.

● The manager had sought advice from the local pharmacy team and had implemented changes to further improve the management of medicines.