The Chaseley Trust

Chaseley

Inspection report

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Ratings

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

Overall summary

Chaseley is a residential nursing home in Eastbourne, providing care for people with a range of complex needs including acquired brain injuries, long term medical conditions, complex medical needs and physical disabilities. Chaseley also provides long and short term respite care, with on site occupational and physical therapy department and gym for rehabilitation and on-going therapies. At the time of this inspection the local authority had an embargo on admissions to the home pending the outcome of on-going safeguarding investigations. There were 36 people living at Chaseley.

At the last inspection 10 June 2014 we asked the provider to make improvements for care and welfare of people who use the service, management of medicines and assessing and monitoring the quality of service provision. The provider sent us an action plan stating they would have addressed all of these concerns by October 2014. At this inspection we found that some actions had been taken, however, improvements were required to ensure systems were fully embedded. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

This was an unannounced inspection which took place on 18 and 19 November 2014.

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

Staff had safeguarding adults training and understood their responsibilities to report any concerns if they suspected abuse. However, one incident had not been reported appropriately by the provider to the local authority for review and there had been a delay in reporting other incidents. Some incidents required notification to CQC and this had not taken place in a timely manner, and in one instance no notification had been completed at the time of the inspection. This meant that people had not been protected from the risks of abuse as the provider had not reported accidents and incidents to the relevant authority for investigation and in a timely manner.

Risk assessments had been completed however, these did not always give an accurate picture of people's needs. There were inconsistencies in care documentation. This meant that staff did not always have up to date guidance on the individual needs of people.

A high number of agency staff were used, and there was an on-going recruitment program. Staff received an induction before commencing work, and all appropriate recruitment checks had been completed. Staffing levels had at times dropped below the designated ratio during night and day shifts. People spoken with raised concerns about the numbers of agency and new staff.

Chaseley had a system in place to record staff training. This was a new computer system and was still in the development stages. The current system was not easy to use and did not allow oversight of each staff member and the training attended.

Policies and procedures were seen. Guidelines for 'as required' medicines were not in place in all files and information for staff regarding the administration of 'as required' medicines was not always clear. Some assessments had not been reviewed within the timescale stated, this included self-administering medicines.

Staff did not have an understanding or adequate knowledge of the Mental Capacity Act 2005 (MCA) or Deprivation of Liberty Safeguards (DoLS). It was unclear how staff had made decisions about people's capacity to make decisions about their care. No DoLS training had been provided at the time of the inspection. People had been supported to maintain their independence with regards to self-administering medicines when this was appropriate.

Chaseley had support from visiting professionals. This included chiropodists, on-site occupational therapists and GPs.

There was a system in place detailing when staff received supervision. However supervision had not happened every eight weeks as stated in the organisations supervision policy. No staff appraisals had taken place; these were scheduled to commence in January 2015. Currently there was no robust mechanism in place to ensure that management were monitoring staff performance and providing regular feedback. This would help ensure staff performance was safe and encourage continual improvement.

Staff had access to policies and procedures; this included a whistle blowing policy. Providers must have policies in place to inform staff of the correct procedures to follow.

People had their nutritional needs met. Choices were offered and people were asked for their feedback about meals provided.

People told us they thought the staff at Chaseley were caring. Staff knew people well and we saw staff communicating with people in a dignified manner.

Systems were in place to ensure equality and diversity needs were met, people were supported to maintain their independence and staff knew people's preferences and religious needs and ensured these were met. People felt staff cared for them well and supported their choices and decisions.

Care files were kept in people's rooms with further information stored in the nurse's office on each floor. When people were not in their rooms we saw doors were left open. This meant that people's confidential information and documentation was not stored securely.

Summary of findings

People had care plans, which were called 'rehabilitation strategies'. However, not all of the information included in them was clear. Inconsistencies were also found in people's care plans and risk assessments.

There were regular activities and people had access to a variety of art and crafts. Activity information was displayed around the building advertising forthcoming activities and events.

Care files included information about people's likes and dislikes. We saw that some of this information had been included in 'pen pictures'. Not all pen pictures had been dated; therefore it was unclear how up to date or relevant the information was.

There was a complaints policy and information regarding the complaints procedure was available. Analysis of complaints did not include completed information to show actions had been taken.

The registered manager was due to leave Chaseley in the near future. A new interim manager had recently been appointed with a view that they would take over from the current registered manager when they left. People told us that there had been a number of staff changes and this had not always impacted positively on the culture within the service. However, we were told a new team leader role had been developed and this had a positive impact on how shifts were allocated.

The provider and management team carried out a number of audits within the service. These had not always been updated to show actions had been taken to evidence lessons learned or that the improvements had been made.

People, staff and relatives were able to feedback their views, experiences and suggested areas for improvement.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement 

The service was not always safe.

Although people told us they felt safe, care documentation and risk assessments included inconsistencies.

Some areas of medicines needed to be improved to ensure they were safe.

Policies and guidance were not clear for some areas of medicine administration.

Staffing levels were not always maintained.

People were supported by staff to self-administer their medicines when appropriate and felt this helped them to maintain their independence.

A contingency plan in place to deal with an emergency.

Is the service effective?

Requires Improvement 

The service was not always effective.

Staff did not have a good understanding of the Mental Capacity Act 2005 and no training had been provided. The registered manager could not demonstrate how decisions about people's capacity had been made.

There was no robust mechanism in place to ensure that management were monitoring staff performance to ensure this was safe and encourage continual improvement.

People were supported to make choices at meal times and for those people who required special diets this information was provided to the kitchen staff.

Multidisciplinary reviews of care took place; these were attended by the individual, their relatives and care professionals involved in their treatment.

Is the service caring?

Good 

The service was caring.

Staff knew people well and were able to communicate with them appropriately and in a dignified manner.

Staff took the time to speak to people and ensured that they answered queries and offered assistance.

Equality and diversity needs were met. For people who lived independently they were involved in decisions about how they lived their lives and spent their time. For people who required more support relatives and next of kin had been involved in decisions.

Summary of findings

Multidisciplinary reviews took place; these were attended by the individual, their relatives and care professionals involved in their treatment.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not correspond with information on assessment forms. This meant care provided may not be consistent.

There were regular activities and people had access to a variety of arts and crafts.

Complaint information did not include information to demonstrate actions had been taken.

Is the service well-led?

Inadequate

The service was not always well led.

There was not a robust system in place to assess the quality of service provision.

Notifications had not always been reported appropriately or in a timely manner.

People told us there had been a number of staff changes including management and this had impacted negatively on the culture within the service.

Chaseley

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 18 and 19 November 2014 and was unannounced.

The inspection team consisted of five inspectors.

Before the inspection we looked at information provided by the local authority, contracts and purchasing (quality monitoring team) and safeguarding investigations. We also looked at information we hold about the service including previous reports.

During our inspection we observed how staff interacted with people. We looked at how people were supported in the communal areas of the service. We spoke to ten people, relatives, friends and other visitors. We spoke to 20 staff; this included the nominated individual, registered manager, interim manager, registered nurses, support workers, agency staff, administration office staff, maintenance, housekeeping and the chef. We also spoke to the visiting GP on both days of the inspection.

We looked at care documentation for eight people. This included care and support plans, risk assessments, incident /accident records, medicines, nutrition and medicine administration documentation and records for everyone living at Chaseley.

We looked at staff files and training records and seven staff recruitment files. We also looked at staffing rotas, minutes of meetings with people and staff, menu's, and records relating to the management of the service such as audits and policies.

On this occasion the provider was not been asked to complete a Provider Information Return (PIR) by CQC. 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. This was because the inspection was bought forward due to the need to follow up on previous concerns.

Requires Improvement

Is the service safe?

Our findings

People spoken with raised concerns about the number of agency and new staff. People felt that the inconsistency of staff caused concern as there had been a high number of staff changes. We were told, "Certain individuals are good but they don't stay." However others said, "This is my home, staff are good, I feel safe, I wish they were just left to get on with their jobs, they are looking over their shoulders all the time. The home needs to be able to move on now." And, "The staff are wonderful, I have lived in other homes, this is by far the best, they help me do things I could not do before."

We looked at how the service managed risk. Care files included risk assessments. Moving and handling risk assessments had been completed using a generic form. This was a tick chart where the assessor chose options to tick to give an overall result. Due to the variety and range of needs for people at the service the risk assessment process for moving and handling was not accurate or robust. For people who remained in bed and required full assistance with all movement the form stated for general mobility 'not walking at present'. This was not an accurate description for people who were not able to walk due to their long term health related condition. For people who remained in bed the risk assessment stated in the likelihood of falling 'does not fall'. It was clear from talking to staff that equipment was used to assist with moving and handling. Therefore there was a possibility that the individual could fall during a procedure. Risk assessments also stated staff did not require special training, although equipment was in use to move these people at all times. Records were misleading regarding people's support needs. Inaccurate records could put people at risk of receiving inappropriate care. Risk assessment tools did not reflect the complex needs of the people who use this service. This is an area that needs to be improved upon. For people with independent lifestyles risk assessments were in place to support and enable day to day risks as part of maintaining their independence.

The provider had plans in place to deal with an emergency. Personal evacuation plans had been written for people, these included specific information regarding equipment, staff assistance required, assembly point and the location of an evacuation lift. There were no suitable premises in the area to be able to provide immediate alternative accommodation for people with specific support needs, in the event of the entire building being out of commission. We were told in this situation staff would liaise with the local hospital.

Chaseley had allocated maintenance workers. Staff were able to report faults or repairs. A log book system had been introduced to record all maintenance work carried out. Personal appliance testing had been completed as well as equipment servicing and maintenance.

Fire alarm testing took place regularly with no current issues found. A fire safety and emergency lighting check had been done in October 2014 with no issues noted. Some inspections including a 'safe environment hazard' inspection which took place in July 2014 had issues detailed which had not been documented as resolved. Therefore the provider could not be sure if these issues had been addressed. Appropriate certificates were in place for water system and legionella checks.

Training had taken place; this included safeguarding adults at risk. All staff had access to the telephone numbers to report concerns directly to the local authority safeguarding team. These were also given to agency staff at the beginning of their first shift. Staff told us they would raise concerns with senior staff on duty but understood their responsibility to raise concerns with outside organisations if appropriate.

The provider followed thorough recruitment processes that ensured staff employed were suitable to work and had the appropriate skills and qualifications to undertake their allocated role. There was a written recruitment policy that was adhered to. There were dedicated staff that worked within the human resources department with allocated responsibilities with regard to staff recruitment. Records identified that prospective staff provided required information to confirm their identity and right to work. Checks completed included criminal records and contact with previous employers regarding conduct. Recruitment interviews were undertaken and job specification and planned questions on situations that may occur were used to assess people's skills and approach. A health check was undertaken once a position had been offered through an external health group.

The provider had an on-going recruitment process. We met a newly recruited registered nurse (RN). We were told another was due to start and a third was awaiting some

Is the service safe?

recruitment documentation before they began working. Support workers (SW's) were also being recruited. We spoke to a member of staff who had worked at Chaseley as an agency worker and was in the process of commencing permanent employment at the service as they enjoyed working at Chaseley. To maintain staffing levels the provider regularly used agency staff including RN's and SW's. Staff told us that regular agency staff were used when available although this was not always possible. We spoke with agency staff who told us they had shadowed other staff to ensure they were able to provide care to people safely.

People could not always be assured of a consistent level of care as there were not sufficient numbers of care staff at all times. Staffing rotas for the last three months showed that there were occasional days when staffing levels were below that which the registered manager had told us. Staff confirmed there were times when they were short of staff. We discussed one occasion with the registered manager when only one RN had been working at night. We were told this was due to an agency worker letting them down at the last minute. Steps had been taken to cover the shift at short notice. People spoken with raised concerns about the numbers of agency and new staff and the effect on continuity of care this caused. This is an area that needs to be improved upon. The provider had taken steps to actively recruit, so staffing levels could be maintained to help ensure people were safe living at the service, and inductions carried out to ensure new staff were adequately trained and supported to provide safe care.

During the inspection we heard call bells were answered promptly and people requiring one to one care had this provided. Staffing ratios were in place. However, it was unclear how dependency levels were assessed as there was no system in place to identify fluctuating levels of need for each person. The registered manager told us there should be no less than three RNs during a shift, with eight SW on both the first and second floor during the day. Staff were divided to work on the first or second floor, with care provision for people with rooms on the ground floor divided between the staffing on each floor.

We looked at accidents and incidents within the service. When these had involved agency workers this had been reported to the agency and in some occasions the provider had requested the individual did not do any further shifts. When incidents required disciplinary procedures, these had been commenced following Chaseley's disciplinary procedures.

At the last inspection 10 June 2014 we asked the provider to make improvements in the management of medicines. The provider sent us an action plan stating they would have addressed all of these concerns by October 2014. At this inspection we found that there were still some areas of medicines that needed to be improved to ensure they were safe.

Guidelines were seen for 'as required' medicines. As required medicines are prescribed by people's GP and are to be given according to the prescription when needed. These are known as 'PRN' medicines. PRN guidelines were in place for pain killers and some laxatives however, they were not in place for everyone to ensure medicines were consistently administered. There was no guidance in place for a person with epilepsy who was prescribed a specific PRN medicine. This was important to ensure all staff knew how to administer this specific medicine safely and effectively in the event of a seizure. The MAR chart held some guidelines on use, but this was not detailed to explain exactly when the PRN should be administered. This was important to ensure medicines were administered promptly and consistently when required.

People who self-administered their medicines had an individual risk assessment in place. However, this had not been reviewed on a monthly basis as indicated on the assessment. This meant that the service could not be sure that people were safe and medicines had been taken appropriately.

Medicine Administration Records (MAR) charts included correct information in relation to allergies that cross-referenced to people's individual files. Each record had a photograph to aid identification and was clear and well completed. When changes had been made to dosages these had been signed and dated mostly by the prescribing GP and described on the back of the chart. Records clearly recorded what medicine each person was prescribed and when they had been administered. An omission found on the MAR chart related to the morning of the inspection. The agency nurse who was in charge of medicines said that the medicine had been given but not signed for. They corrected the record when it was highlighted to them.

Requires Improvement

Is the service safe?

One person's record relating to a variable dose medicine was clear and recorded the correct dosage administered and up to date information from the hospital clinic to reference. Prescribed creams were recorded on the MAR charts. Creams for regular use were recorded on charts within people's rooms.

Some prescription medicines are controlled under the Misuse of Drugs Act 1971 these medicines are called controlled drugs or medicines (CD). These have specific procedures which are required to be followed with regards to their storage, recording and administration. The CD records were accurate and reflected the CDs stored on the premises. Safe storage arrangements were in place. Administration of a CD was done correctly with two registered nurses in attendance.

There were new policies that were service specific for Chaseley on the ordering, receiving of medicines, safe administration and disposal of medicines. We saw that suitable sharps bins were available and containers for medicines to be returned to the pharmacist were in place in each of the medicine rooms. Storage facilities were appropriate and the temperature around these areas was being monitored.

There were allocated staff in charge of ordering and checking the prescribed medicines on a monthly basis. There was a system to order medicines prescribed or changed mid cycle with the use of a fax machine. This system ensured people received their prescribed medicines consistently. A staff member showed us an example when a course of antibiotics finished. The GP wanted the anti-biotic to continue. This was ordered which allowed the medicine to continue without any gap.

Other policies were generic. Including the warfarin procedure. We were not able to locate procedures to be followed when people took social leave. An agency nurse had given medicines to a person who was going out for the day. She said she had just done what had been done for another person who had been on leave when she was last working. It was unclear what the policy was in regards to this. We saw two RN's administering medicines. We observed they followed good practice guidelines.

Three staff, including an agency nurse said they were competent and felt they had the skills to administer the medicines safely. The agency nurse was administered medicines on her second shift in the home and told us they felt adequately supported and trained to do so. An RN confirmed she had worked the first shift with this agency nurse who had completed the evening shift on her own with the support of a senior carer to help her identify the correct people.

Audits did not reflect action taken to resolve and improve medicine management. Weekly audits were undertaken which identified some omissions in record keeping but allowed for these to be followed up with the RNs concerned. A monthly audit was also completed which continued to identify medicine issues. Areas identified with regards to medicines showed that actions had been taken by the provider however, some areas need improvement.

Requires Improvement

Is the service effective?

Our findings

People told us they felt they received effective care. Chaseley provided care for people with a range of complex needs including acquired brain injuries, long term medical conditions, complex medical needs and physical disabilities. Due to the range of care needs staff required specific training to provide effective care to suit people's individual needs. People did raise concerns regarding the number of new staff as staff turnover was high and agency staff were covering shifts. One person told us, "You never know who is going to walk through the door; there are so many different people."

CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). Staff had not received training in relation to DoLS. Staff did not have an understanding or adequate knowledge of DoLS or the Mental Capacity Act 2005 (MCA). The nominated individual and registered manager confirmed no training had been provided. One care plan stated a person had limited capacity in all areas related to their care. However, no evidence was seen to explain how this decision had been made. Staff told us and the registered manager confirmed there had not been a best interest meeting or mental capacity assessment completed. This meant that decisions had been made about this person's capacity without proper procedures and assessment taking place to protect them and their right to be involved in care decisions.

There was a 'do not attempt resuscitation' form in one person's care file. This had been signed by a power of attorney. However, the care plan stated this person wished to be resuscitated. There was no mental capacity assessment for them, so it was unclear if this person had capacity to be involved in this decision. One person had been asked to make a decision regarding the reporting of an incident that had occurred. No mental capacity assessment had been completed; therefore it was unclear how the staff had assessed this person's capacity to make this decision. There were not suitable arrangements in place for obtaining and acting in accordance with the consent of people. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us they felt that training opportunities were available. The provider had dedicated staff for arranging training and a new computer system recently implemented to record staff training undertaken. However, this was still in the development stages. The system currently in use did not have a process to follow up when staff did not attend training; it was unclear what was in place to ensure that non-attendance was picked up and acted on promptly to ensure all staff remained appropriately trained. The registered manager told us once fully running the new system would highlight if people had out of date training or had not attended training with a reason for this included. This is an area that needs improvement.

Staff told us they had training to enable them to provide effective care for people. During the inspection we saw training information which showed that some staff were due to attend 'compassion awareness' training at a local hospice that day and 'equality and diversity' refresher training was also arranged, with staff listed who were due to attend. We were able to look at essential training to ensure staff were able to undertake their role effectively and identified dates when staff had attended. Further training had also been provided for staff by a number of external organisations. This included the local hospice and companies providing medical services to Chaseley.

New staff received an induction which included shadowing another staff member. We spoke with agency staff who confirmed they had also shadowed for some of their first shift to ensure that they were orientated and able to provide care effectively.

Staff files contained evidence of qualifications and additional training undertaken. We were shown the system used to check that the nurses working had maintained their registration as required with the governing professional body on an annual basis. Staff performance was reviewed following a period of probation. Each file contained a job description which identified roles responsibilities and who people reported to.

Staff supervision had not happened every eight weeks as stated in the organisations supervision policy and no staff appraisals had taken place. There was a system in place detailing when staff received supervision. The supervision spreadsheet noted that that some supervision had taken place and three out of nine care staff spoken with told us they had supervision with a senior staff member in the last month. The registered manager and nominated individual confirmed that supervision was a 'work in progress'. No appraisals had taken place and the registered manager told us these were scheduled to commence in January

Requires Improvement

Is the service effective?

2015. At the time of inspection there was no robust mechanism in place to show how the manager regularly monitored staff performance or carried out clinical supervision to encourage continual improvement. This is a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Multidisciplinary reviews of care took place; these were attended by the individual, their relatives and care professionals involved in their treatment. Chaseley had support provided from visiting health care professionals. This included chiropodist, on site occupational therapists and GPs. We spoke with people and visiting professionals who told us they had attended multidisciplinary reviews and found these to be effective. People told us they were happy to be involved in reviews. We saw reviews with actions included, however it had not been documented to show whether these had been completed.

People had a range of nutritional needs. This included nutritional support via feeding systems, soft, pureed and specific dietary needs. Some people were independent and chose not to eat all of the meals provided by the service. People ordered take away food and went out for meals when they chose or when family were visiting. Staff were aware of the need to ensure people were provided with information about healthy eating options but facilitated people to remain independent with eating and drinking choices when appropriate.

A bar was available for people and visitors to use, this also provided snacks and hot drinks. We saw that people and visitors used this area, and there was an outside seating area which could be assessed via a slope for wheelchair users.

People were given choices at meal times. Some people chose to eat in the main dining room and others chose to eat in their rooms. People told us the food was, “Excellent, plenty of choice.” “Really good” and “Boring, but okay.” We spoke to the chef and looked at the menu. There were three choices for people and for people who required special diets this information was provided to the kitchen staff and appropriate meals were provided. During mealtimes staff were seen to sit with people and assist them with their meals at an appropriate pace. People were asked for daily feedback about the meals provided. Feedback forms were readily available on the dining tables and taken to people’s rooms who ate there. People told us they gave regular feedback and had the opportunity to make suggestions and requests with regards to the meals provided.

The home had been built to provide access for people using wheelchairs. The dining room had specially adapted tables which could be moved to the correct height for people in motorised wheelchairs to enable them to sit at the table and eat. There was specialised cutlery and crockery to facilitate people to maintain independence when eating. Food appeared well presented. We saw there were comment cards on each table and these were available to people who ate in their rooms. This gave the chef daily feedback on the meals provided and people were able to add comments about their likes and dislikes.

There were on site occupational and physical therapy departments and gym for rehabilitation and on-going therapies. People felt that the occupational therapies were effective with a dedicated therapy team to assess peoples individual needs to ensure therapies were suitable and effective

Good

Is the service caring?

Our findings

People told us they thought the staff at Chaseley were caring. People told us, “I feel that staff always treat me in a dignified way, even when they take me for a shower, I am nicely covered up and kept warm.” And, “Staff are lovely, I am able to do so much more now than I could when I came here, they take the time to help me.”

It was clear from watching staff talk to people that they knew people well and were able to communicate with them appropriately. For people who could not communicate verbally staff told us how communication was facilitated, for example one person answered by blinking and staff were able to tell us about this and how they looked for signs that this person may be in pain or unhappy. We observed staff interacting with people which was done in a kind and caring manner. We saw one person stop staff in the corridor. Staff took the time to speak to them and ensured they answered this person’s query and offered assistance. We spoke to this person who told us “I like to talk to staff and visitors, as staff are good, this is my home.”

Staff spent time liaising with the visiting GP discussing people’s medicines and their changing needs. When staff entered people’s rooms they spoke with people in a kind way, and took time to chat to people when they wanted to talk.

At the last inspection 10 June 2014 we asked the provider to make improvements for care and welfare of people who use the service. The provider sent us an action plan stating they would have addressed all of these concerns by October 2014. At this inspection we found that people had been involved in the planning of their care.

We looked at care files and asked people whether they had been involved in writing the care documentation. Care plans had been called ‘rehabilitation strategies’. One person told us, “They talked to me about it, wrote it then came back and read it to me; I made a couple of changes then signed it.” For people who were unable to communicate verbally it was not clear what steps had been taken to involve that person in care decisions. Care plans did show relatives and next of kin involvement in care planning. We spoke to a senior nurse who had been given the task of re-writing all the care plans since our last inspection. They told us how they involved the individual, their families or next of kin, and the person’s keyworker when possible. Information gathered had been used to write the care plans.

Information was provided if people required advocacy services. A number of volunteers attended the service. Volunteers assisted with day to day activities around the service and trips. The registered manager told us that volunteers assisted people to complete surveys and questionnaires if needed.

People were cared for in a caring and dignified way. People were appropriately covered when going for or returning from the bathroom or shower. People had their doors closed when personal care took place. Two people liked to have their doors left open throughout the day. This information had been included in their care documentation. We spoke with both who confirmed they liked the door open so they could see people going past, and that staff closed the doors when personal care took place. Staff knocked on people's door and waited for a response before entering. Staff took time to explain to people what they were doing. Staff used people's preferred name when speaking to them and maintained eye contact when talking with people.

People’s equality and diversity needs were respected for example people took pride in their appearance and staff supported them to dress in their preferred way. We saw that it was important to one person that they feel feminine and wear jewellery. This information was included in their care documentation. They were wearing jewellery during the inspection.

For people with an independent lifestyle there was a system in place to ensure they were involved in decisions about how they lived their lives and spent their time. For people who required more support, relatives and next of kin had been involved in decisions. People’s religious and spiritual needs were documented in their care files. One person told us they attended regular church services and that staff supported them to access religious material and attend services when they wished. They felt that staff understood their religious preferences. On days when they were being taken out by friends staff were aware when they needed to be dressed and ready and ensured this took place.

Requires Improvement

Is the service responsive?

Our findings

People who were independently mobile told us they had plenty to do. A number of daily activities were available for people to access if they wished. There was a room used for painting and other art related activities, a meeting/ television area, IT suite and a bar/cafe area could be used by people living at Chaseley, their relatives and visitors. Activity information was displayed around the building. Arts and craft activities were available most days, and people went out regularly with family or friends. People who chose to stay in their rooms or who remained in bed told us "I keep myself busy, I have plenty to do." And "I do get bored sometimes."

One person's file stated staff should ensure that the person was engaged in activities or they could become bored. This person's daily records did not record how staff ensured that this took place. The person told us staff regularly asked if they were, "Okay" but did not engage in any specific activity with them. Staff told us this person had been encouraged to leave their room more frequently but declined to do so. We did not see documented evidence to support this. Therefore this person's individual needs were not always being addressed.

Care plans or 'rehabilitation strategies' had been re-written using a new format. All of these had been written by one member of staff who told us they had not received any specific record keeping training and it was the first time they had written care plans using this format. These had been written in the first person as if by the person. They stated 'I' throughout and specific medical instructions for staff appeared as though they had been decided by the individual. However, for many people who were unable to communicate this was not the case. This was misleading as people had not written their own care plans and the title of the care plans as 'rehabilitation strategies' was not appropriate for all people living at the service. Care plans were therefore generic and not in response to people's individual needs.

Information provided in care plans did not always correspond with information on assessment forms. This meant care provided may not be consistent. We read in two care files people required blood glucose monitoring three times a day. We looked at MAR charts and spoke with staff who told us this was done twice a day.

Not all care files included a completed waterlow chart. Waterlow is a tool used to monitor pressure area risk. Due to the range of people's complex needs this would be required. Those that did have a waterlow chart, had not all been reviewed within the stated timescale, therefore people may be at risk of developing pressure areas. Nutritional care plans stated a person required to be weighed weekly. This had not taken place with only monthly weights documented. This meant that staff would not be aware of weight concerns in a timely manner; this could impact on this person's health. Regular weight monitoring is essential for people with special dietary needs or those receiving nutritional support via feeding systems to ensure that they are receiving adequate nutrition. Weight monitoring is also important to ensure pressure relieving equipment for example air mattresses are used correctly as this will be set according to the person's weight.

Care files were kept in people's rooms with further information stored in the nurse's office on each floor. However, when people were not in their rooms we saw doors were left open which meant that personal information was not stored securely and could easily be accessible by others.

People were not always protected from the risk of unsafe or inappropriate care as accurate records had not been maintained or, stored securely. This is a breach of Regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Clinical records such as fluid charts had been completed appropriately when required. People who had pressure relieving mattresses had this documented in their care files. Daily checks had been completed by staff to ensure these were appropriately set and equipment was working effectively.

Peoples care files included information about their likes and dislikes. Some of this information had been included in 'pen pictures'. Pen pictures were a summary of peoples care needs, likes and dislikes and were used by staff as an aide memoire. However, not all pen pictures had been dated; therefore, it was unclear how up to date or relevant the information was. Care files also included information about people's lives before they moved to Chaseley, their preferences and religious /spiritual needs. This is an area that needs to be improved.

Requires Improvement

Is the service responsive?

Some people told us they went out daily and one person was due to go out with a member of staff during our inspection. People told us they felt encouraged to maintain their independence. People were supported to maintain relationships with friends and family. Visitors were always welcome at the service and people went out with their family for day trips and visits when they were able to. We spoke to one person who told us that they self-administered their medicines. They told us that staff supported them to do this, and they felt this helped them to maintain their independence.

There was a complaints policy and information regarding the complaints procedure was available to people using the service. People told us they would raise any concerns if they felt they needed to. The complaints policy was generic to the organisation and did not include specific timescales for the provider to respond and actions to be taken. There had been 11 complaints since May 2014. Out of this five had no evidence documented to show actions had been taken. The registered manager told us that not all actions which had taken place had been updated on the spreadsheet. Therefore the registered manager was not monitoring and evaluating complaints effectively. Information had not been completed effectively to show actions taken. This was discussed with the registered manager and nominated individual as an areas in need of improvement.

Inadequate

Is the service well-led?

Our findings

People told us that management had changed frequently and this had impacted on the culture within the service. One person told us, "Things changed a while ago, systems collapsed. There is a lack of direction and lack of leadership." People said they felt staff were generally very good, and told us they had met and spoken with the registered manager and nominated individual and knew how to contact them if they needed to.

At the last inspection 10 June 2014 we asked the provider to make improvements around assessing and monitoring the quality of service provision. The provider sent us an action plan stating they would have addressed all of these concerns by October 2014. At this inspection we found these issues had not all been addressed. A number of audits had been completed by the provider, however actions were not yet clearly documented to show that issues had been rectified and lessons learned. This was evident when we looked at notifications, accidents, incidents and complaints where actions taken were not documented or had not taken place in a timely manner.

We looked at notifications which are completed by the provider to inform the Care Quality Commission (CQC) when certain incidents have taken place. One incident had not been reported by the provider. We also identified delays in the reporting of three further incidents to the local authority safeguarding team and CQC. People had not been protected from the risks of abuse as the provider had not reported accidents and incidents appropriately and in a timely manner. The provider failed to notify the commission without delay of any abuse or allegation of abuse in relation to a person at the service. This is a breach of Regulation 18 of the Care Quality Commission (Registration) 2009.

There had been work done to improve and audit the service. For example medicines and personal emergency evacuation procedures had been implemented, as well as a number of new audits due to start imminently. This included a care plan, infection and pressure sore audit. The newly appointed interim manager told us that a dependency tool was also being developed. However these were not currently in use.

The provider had completed management quality audits for each floor of the service and we read the latest report. The registered manager told us actions had been taken in a number of areas but not all of these had been documented to show they had been actioned and completed. This was a consistent finding in auditing carried out by the provider; actions had not been documented effectively, to evidence that information had been used to drive continuous improvement. This is a continuing breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People had been informed that a new 'interim manager' had been appointed to take over from the current registered manager who was due to leave. The interim manager had been working at the service for less than two weeks. Many staff and people had yet to meet them. One staff member told us, "The care provided here is a high standard, but there is no stability for staff as management keeps changing." Another told us, "Some staff feel supported, others don't, it is not easy when senior staff keep changing, you don't know what is going to happen."

The nominated individual told us there was on-going recruitment for both nursing staff and support workers. Recruitment had been challenging, the nominated individual felt this was in part due to a shortage of availability of appropriate trained nursing staff, and the on-going embargo on admissions to the service. On-going recruitment demonstrated that the provider was proactive and had identified a need to recruit. Active recruitment would continue to ensure staffing levels could be suitably maintained. New staff had completed an induction and shadowed current staff to ensure they were able to meet the needs of people living in the service.

The registered manager and a previous clinical lead, who had recently left the service, had made a number of changes. This included the appointment of team leader roles. Staff told us allocation of staff was now done by team leaders at the beginning of each shift. Team leaders were senior SW's recruited for this role. Staff gave us positive feedback about the implementation of this role and the positive impact it had on the way shifts were organised.

Information was displayed around the home informing people of new staff members and the statement of purpose and values for Chaseley. This helped to keep people up to date with changes to staff. We spoke with management and the nominated individual about the vision for Chaseley in the future. They told us the organisation had been striving to improve levels of staffing and ensure a high level of care

Inadequate

Is the service well-led?

provision. The business plan had been on hold due to the current embargo and plans to move Chaseley forward would be reviewed in the new year when changes and improvements had become fully embedded. Staff who required health and welfare support had access to outside professionals. This included occupational health services.

There was a comprehensive format for meetings within the service. We read minutes for staff meetings which had taken place over a three day period in July 2014. This included information given to staff regarding changes in documentation and the need for continued improvement in all aspects of care provision and professional boundaries. Staff were also given information about the embargo on admissions. Staff told us if they had been unable to attend a meeting then the minutes were available for them to access.

Resident representatives attended regular meetings with a member of the senior management team. Minutes of these meetings were seen and available for people. The most recent meeting in September 2014 had been attended by five resident representatives. Trustees meetings also incorporated meetings with resident representatives to allow them to feedback any issues or concerns. Some minutes read from meetings contained actions which had taken place however these did not always include dates to indicate timescales. This included people's requests for specialised cutlery, and ensuring that wheelchairs were appropriately charged. Questionnaires had been sent out to people to enable the provider to obtain feedback. There had been a low response rate and the registered manager told us they were thinking of others ways to gain people's feedback effectively.

Staff had access to policies and procedures; this included a whistle blowing policy, staff had been given information about whistleblowing at the last staff meeting. Staff told us they were aware of this policy. One staff member told us they had raised a concern but did not feel they were given feedback. Others told us they would not hesitate to raise concerns if they had them and had done so in the past and felt these had been dealt with appropriately.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The registered person had not notified the commission without delay of incidents which occurred whilst carrying out a regulated activity. Regulation 18 (1)(2)(a)(iii)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **Where people did not have the capacity to consent the registered person had not acted in accordance with legal requirements.** **Regulation 18**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The registered person did not have suitable arrangements in place to ensure staff received appropriate training, professional development, supervision and appraisal.** **Regulation 23 (1)(a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **The registered person had not maintained accurate records for all people. People were not protected as records were not kept securely.**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The registered person must protect service users by regularly assessing and monitoring the standard of service provision effectively.** Regulation 10(1)(a)
	Regulation 20(1)(a)(2)(a)