The Chace Rest Home Limited

The Chace Rest Home

Inspection report

Chase Road
Upper Welland
Malvern
Worcestershire
WR14 4JY

Tel: 01684561813
Website: www.thechace.com

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
The Chace Rest Home is a residential care home providing personal care and accommodation for up to 41 people, some of whom have dementia. There were 38 people living at the service at the time of our inspection.

People's experience of using the service and what we found
People were supported in a way that was person-centred and achieved good outcomes. However, systems to review the quality of care and ensure the good governance of the service were not always effective in driving improvements. Quality assurance processes were being improved upon by the newly registered manager, and they recognised some areas still required development.

Risks around people's health and well-being had been identified, but records to demonstrate risk management were not always accurately completed. People had their prescribed medicines available to them, although some improvements were required around the management of 'patch' medicines and 'as required' medicines. The home was clean and tidy, and staff understood their role in minimising the risks of infections spreading.

There were enough staff to meet the needs of people living at the home and staff were on hand and attentive to support people's physical and emotional wellbeing. Staff were trained in safeguarding and understood their responsibility to protect people from avoidable harm, abuse and discrimination. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Staff were motivated to provide good standards of care and we received positive feedback from relatives about the staff team. The registered manager was establishing and improving practices to support positive outcomes for people and worked with other healthcare professionals to ensure people's healthcare needs were met.

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 requires improvement (published 9 May 2019). The service remains rated requires improvement. This service has been rated requires improvement for the last 3 consecutive inspections.

Why we inspected
This inspection was prompted by a review of the information we held about this service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Chace Rest Home on our website at www.cqc.org.uk.

Enforcement
We have identified a breach in relation to Good Governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

The Chace Rest Home

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 Health and Social Care Act 2008.

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
The inspection was carried out by 2 inspectors 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.

Service and service type
The Chace Rest Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Chace Rest Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
Our inspection visit was unannounced.

What we did before the inspection
We reviewed the information we had received about the service since our last inspection. We gathered feedback from local authority commissioners who work with the service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all of this information to plan our inspection.

During the inspection
We spoke with 4 people and 8 relatives to find out what it was like to live at the home. We carried out observations in communal areas to help us understand the experience of people who could not talk with us. We spoke with 9 members of staff including the registered manager, the human resources co-ordinator, the administrator, 3 care staff, 2 housekeeping staff and the activities co-ordinator. We also spoke with the nominated individual who is responsible for supervising the management of the service on behalf of the provider. We gathered feedback from 1 external healthcare professional.

We reviewed a range of records which included 4 people's care records, 5 people's medication records and 2 staff recruitment files. We also reviewed a range of checks the management team completed to assure themselves people received a safe, good quality service.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question Requires Improvement. The rating for this key question has remained Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- People had risks associated with their care which had been assessed. For people at risk of specific health conditions, information was recorded to tell staff how to support that person.
- Staff completed daily records to demonstrate what support had been provided. However, for one person at risk of skin damage, records were not always completed to confirm they had been repositioned at the required time intervals. This person confirmed they were regularly repositioned by staff and the registered manager assured us staff would be reminded to document the level of support provided.
- Regular maintenance work and health and safety checks were completed to ensure the environment remained safe, for example water quality, electrical safety and fire safety checks.
- Weekly checks of window restrictors were completed; however, some restrictors were not the right type or fitted with the correct tamper proof screws or covers to prevent people from removing them. The provider assured us these issues would be resolved.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- The service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Using medicines safely

- People had their prescribed medicines available to them.
- Some people had their medicines administered through a patch applied directly to their skin. Staff were not recording the site of application on a body map to ensure they were applied in line with the manufacturer's instructions. This is important because the correct rotation minimises the risk of skin sensitivities. The registered manager immediately implemented body maps.
- Some people were prescribed medicines to be given on a 'when required' (PRN) basis when they were experiencing periods of anxiety or distress. Care plans contained information about the actions staff should

take to minimise or de-escalate people's distress before the medicine was given. This ensured the medicine was only given if other interventions had been ineffective.
● However, records were not always kept about the circumstances that resulted in PRN medicine being given and whether it had been effective. This information supports other healthcare professionals in making decisions about the prescribing instructions for these types of medicines.
● Some people were given their medicines covertly, that is hidden in food or drinks without their knowledge. Records had been completed to evidence there had been a full mental capacity assessment, or formal best interests meeting to ensure it was in the person's best interests. There was guidance from a pharmacist on safe administration methods.
● Medicines that required additional storage in line with legal requirements were stored correctly.

Systems and processes to safeguard people from the risk of abuse
● People were relaxed with staff and responded positively when staff interacted with them. One relative commented, "Staff are polite, happy and helpful. There is a very nice atmosphere in the home."
● Staff were trained in safeguarding and understood their responsibility to protect people from avoidable harm, abuse and discrimination. They told us they would challenge poor practice and report any concerns to a senior person. One staff member told us, "Abuse can be different; verbal, physical or any act that could cause harm or a feeling of being offended. I would definitely inform the senior right away, and make sure they acted properly."
● The registered manager worked in accordance with their local authority policies and where necessary, referred incidents to the safeguarding team for external scrutiny and investigation.

Staffing and recruitment
● There were enough staff to meet the needs of the people living at the home.
● Our observations showed staff were on hand and attentive to people's physical and emotional wellbeing. Where people activated their call bell, staff attended.
● We received positive feedback from staff about staffing levels which they felt enabled them to provide safe care, and carry out the tasks required to minimise risks to people. Comments included: "We have got enough time to look after the residents and chat with them" and, "I know they keep to the quota they are supposed to have on the system, and they always make sure they have enough staff to do what needs to be done."
● The provider ensured staff were recruited safely and were suitable for their roles by conducting relevant pre-employment checks.
● We reviewed two staff recruitment files and saw appropriate references and Disclosure and Barring Service (DBS) checks. We recommended to the provider they explored and recorded any gaps in employment histories.

Preventing and controlling infection
● We were assured the provider was preventing visitors from catching and spreading infections.
● We were assured the provider was supporting people living at the service to minimise the spread of infection.
● We were assured the provider was admitting people safely to the service.
● We were assured the provider was using PPE effectively and safely.
● We were assured the provider was responding effectively to risks and signs of infection.
● We were assured the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured the provider's infection prevention and control policy was up to date.

Visiting in care homes

● Visiting was allowed and facilitated, however a booking system remained. Whilst the provider assured us unplanned visits would be supported, we reminded them of current government guidelines and to consider if bookings were actually required.

Learning lessons when things go wrong

● Accidents and incidents were reported and recorded but we found inconsistency in the amount of information recorded on accident and incident reports. This meant it was not always clear what immediate actions had been taken to mitigate risk.

● The registered manager reviewed accidents and incidents in the home every month. However, this needed to be improved to support effective analysis and identify any patterns or trends within the service.

● Staff told us information about accidents and incidents was shared through the electronic care planning system.

Requires Improvement

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 requires improvement. At this inspection this key question has remained Requires Improvement. This meant the service management and leadership was inconsistent. Processes were not always effective to ensure improvements were identified and actioned.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The registered manager had systems to review the quality of care and ensure the good governance of the service. However, these were not always effective in driving improvements and maintaining standards.
- We checked examples of audits and found in some cases they were not robust enough to identify when standards were not being met. For example, regular window restrictor checks were made to keep people safe, however, some window restrictors did not meet health and safety requirements.
- Systems to analyse and review accidents and incidents were not sufficiently robust to identify any patterns or trends within the service.
- Where governance systems had identified issues, effective action had not always been taken to ensure improvements were made. For example, audits had identified some discrepancies with the recording of the administration of 'when required' medicines. We checked one person's PRN medicine and the amount in the box did not reconcile with the total amount recorded on the Medication Administration Record (MAR).
- Care plans were not always updated when a person's needs had changed, and in one example, aspects of a person's health condition was written in four different care plans. This made it complicated to understand the condition and how to support the person. Another person's risk of absconding had increased, yet analysis of those incidents and events had not been fully considered. Some strategies put in place to help meet this person's needs impacted on other people's enjoyment of the home.
- We acknowledged quality assurance systems were being improved by the newly registered manager. However, at this visit, we could not be confident the systems were fully utilised and managed robustly.

Systems were not always operating effectively to assess, monitor and improve the quality and safety of people's care. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People were supported in a way that was person-centred and achieved good outcomes. One relative told us, "[Name] now has a much better quality of life and I couldn't believe the difference in her." Another relative commented, "I really see a calm environment with happy residents. It has a nice feel about it."
- Relatives spoke of improved standards of care and communication under the newly registered manager and how this had benefited the home. Comments included: "There is a different atmosphere for the better" and, "It has improved with new management, and they are good at communicating."

● Staff were motivated to provide support that was responsive to people's physical and emotional needs. One staff member described their responsibility to, "Enhance and enrich [people's] lives while living at the Chace."
● People and relatives gave positive feedback about the staff team. One relative told us, "Staff give the impression they all have their vocation in caring."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
●The registered managers told us key messages were communicated internally where required. Staff confirmed this and told us they felt communication within the service was good.
● People and relatives were kept up to date with events in the home through a regular newsletter and asked for their feedback through questionnaires.
● The results of the most recent questionnaire were being compiled at the time of our inspection. We sought assurance from the registered manager that a concern around manual handling techniques on one feedback form had been immediately responded to.

Continuous learning and improving care
● The provider told us they were proud of the home and the work already completed to make The Chace a home to be proud of. The provider told us, "I think we have made massive strides. The old care manager left, and we started to look at the bigger picture. Now, I come in and it's the finer detail."
● The provider and registered manager were told about some of the improvements we found and gave a commitment they would be addressed. Following our inspection, the registered manager sent us confirmation of the actions taken in response to our feedback.

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 registered manager understood their responsibility to be open and honest when things had gone wrong. The registered manager was open with us during our visit, telling us what they had identified had improved and where areas still required development.
● The provider had met the legal requirements to display the services latest CQC ratings in the home and on their website.

Working with others
● The registered manager was establishing and improving practices to support positive outcomes for people. They had signed up to improving their knowledge and practices with Skills for Care and CQC. Skills for Care is a nationally recognised organisation providing education, training and research for those who work in health and social care.
● The registered manager worked with other healthcare professionals to ensure people's healthcare needs were met. For example, district nurses who supported people with pressure care management and the management of diabetes. A visiting healthcare professional told us of "good standards" within the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 17 (1) The provider's systems and processes were not always operated effectively to assess, monitor and improve the quality and safety of the service provided.