The Chace Rest Home Limited

The Chace Rest Home

Inspection report

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Date of inspection visit:
19 February 2016
22 February 2016

Date of publication:
08 July 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 19 and 22 February 2016 and was unannounced.

The provider of The Chace Rest Home is registered to provide accommodation and personal care for up to 41 people. At the time of the inspection there were 40 people lived at the home.

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

People did not have their medicines administered and stored in a safe way. The staff practice did not follow the procedures written by the provider and these increased the risk of cross infection. This is a breach of the regulations because the registered person had not ensured the safe management of medicines.

There were some arrangements in place to assess, monitor and improve the quality of the care but these were not always effective. This is because the checking systems had not identified some areas that required improvement actions to be taken. We saw staff did not always follow the risk assessments advice when helping people putting them at potential risk.

People were kept safe from potential abuse and harm by staff who understood how to identify the various types of abuse and knew who to report any concerns to. Staff were trained and supported to meet the needs of people who lived at the home. Checks had been completed on new staff to make sure they were suitable to work at the home.

People enjoyed the food they received and but food and drinks were not consistently monitored to ensure they stayed healthy. When people needed it they had access to a range of healthcare professionals to make sure they remained healthy and well.

People were not always treated as individuals, as staff didn't always know people's needs and their individual preferences. Most interactions between people and staff were task orientated.

People knew how to complain and felt able to discuss concerns with the registered manager. The registered manager was visible in the home so people felt able to approach them to discuss their concerns.

You can see what action we have asked the provider to take at the back of this report.

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

This service was not consistently safe.

People did not have their medicines stored or administered in a safe way. Risk assessments were in place for people but staff didn't always follow the guidelines placing people at unnecessary risk.

Is the service effective?

Good

This service is not consistently effective.

People's dietary needs were assessed and a varied menu of regular meals. Snacks and drinks were provided, although were not recorded and monitored to ensure people had enough to eat and drink to stay healthy. People had their health care needs met because the provider sought advice and support from relevant health care professionals.

Is the service caring?

Requires Improvement

The service is not always caring.

People's personal information was not stored securely and so didn't protect people's right to confidentiality and people were not always treated with dignity and respect.

Is the service responsive?

Requires Improvement

This service was not always responsive.

Staff didn't always know information about the person they cared for and what was important in their life. This meant the service could not be sure it provided support which was in line

with people's wishes. Not everyone had opportunities to pursue their hobbies and interests. People knew how to make a complaint and felt this would be listened to and action taken to resolve their complaints.

Is the service well-led?

Requires Improvement

This service was not consistently well-led.

Quality Audits in place failed to identify shortfalls in people's medicine administration and care plans. Although the registered manager was open to feedback from people using the service and relatives, there was a lack of regular feedback opportunities which were used to continuously improve the service delivery to people.

The Chace Rest Home

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 was planned to check 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 19 and 22 February 2016 and was unannounced.

The inspection team consisted of one inspector and a specialist advisor who had experience of working in this type of service. They had experience of caring for older people. On the 22 February 2016 the inspector returned to the home to conclude the inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form the provider completes to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the PIR and we took this into account when we made the judgements in this report.

We checked the information we held about the service and the provider. This included notifications received from the provider about deaths, accidents and any incidents of potential abuse. A notification is information about important events which the provider is required to send us by law.

We requested information about the home from the local authority and Health Watch. The local authority has responsibility for funding people who used the service and monitoring its quality. Healthwatch is an independent consumer champion, which promotes the views and experiences of people who use health and social care.

We undertook a Short Observation Framework for Inspection (SOFI) during the inspection. SOFI is a specific way of observing care to help us understand the experience of people who could not speak directly with us. We also spent time in the communal areas of the home to see how staff provided care for people.

We spoke with seven people who lived at the home and three relatives who were visiting at the time of our

inspection. We also spoke with the registered manager, two senior staff and four care staff and the chef.

We looked at a range of documents and written records. These included three people's care records and people's medicine records, three staff recruitment files, and training and induction records. We also looked at the information about the arrangements for managing complaints and keeping people safe. We also saw records which showed us how the registered manager and provider monitored the quality of the service provided within the home.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection on 19 and 20 May 2015 we found the provider did not have suitable arrangements in place. This is because they had not ensured people who lived at the home were protected against the risks associated with unsafe use and management of medicines. At this inspection we found further improvements were still required.

We saw some people's medicines were not always administered in a safe way. Hand washing by staff had not been performed prior to commencing medication administration, this is important to people's safety to prevent cross infections. We saw a member of staff used one medicine pot for more than one person and touched the medication with their bare hand. We saw one person potentially risk missing their medication because staff recorded it as given although it was still in the medication pack. We had to remind the member of staff to give it to the person. We noted there was no water available for the person receiving their medication. The provider's own medicine policy was not consistently followed; it stated staff should "use oral syringes with bottle stoppers to dispense small volumes." However we saw liquid medications were measured on a spoon, instead of the appropriate pot with measurements for accuracy.

Medication stock was stored in the registered manager's office in a locked cupboard however the key was not kept in a secure place so anyone visiting the home could potentially have access to people's medicines. .

We checked how the provider stored people's controlled drugs. Controlled drugs are medicines which need special storage arrangements. We saw they were stored securely and administered by two members of staff to reflect they were managed in accordance with the provider's medicines policy. When we checked the controlled drugs we found the documentation not to be accurate in the recording book, we found medication which had been issued in 2013. This meant the medicine audits and returns of these medications, was not effective, good medicine administration practice recommends any unused medicines are returned to the pharmacy as soon as possible for them to be disposed of safely.

At this inspection the registered manager told us the provider had invested in a new electronic medication recording system to improve of the administration of medication.The registered manager used of the new system completed a daily audit of medicines. This meant they monitored the management of medicines and so errors identified they could be rectified in a timely manner. Although medicine audits were in place they were not robust because they did not pick up people's medicines should have been ordered.

This is a breach of regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014, because the registered person had not ensured the safe management of medicines.

The provider had a medication policy which provided staff with guidance, in addition to this staff received medication training. Once this had been completed, staff were observed, by the care co-ordinator, administering medicines on four separate occasions before being signed off as competent to administer medicines. The provider had individual risk assessments in place for people such as how to move people safely. These provided staff with guidance about the support people needed to keep them safe. However we

saw staff did not always follow these guidelines in order to protect people from unavoidable risks. This is because we saw two staff helped a person move from their seat into a wheelchair without foot rests and without the brake being put on first.

Risk assessments were in place to ensure people had the support they needed should there be an emergency event within the service. The provider had a fire safety policy and we saw regular fire tests and associated checks took place. The registered manager had also taken advice from external professionals when assessing risks to, such as the fire service.

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The registered manager showed us how she recorded accident and incidents and monitored people's falls within the home. They showed us action they had taken when someone had recently fallen to reduce the risk of this happening. For example, the person's medication was reviewed because it was thought this might have been the cause.

Staff demonstrated a good understanding of how to safeguard people from abuse who used the service, they were aware of the types of abuse and how to report concerns. Staff told us they would ensure any immediate action was taken to keep the person safe and then they would share the concerns with the registered manager. Staff we spoke with knew who they should contact if they had any concerns about practices which might place people at risk of harm. None of the staff we spoke with had needed to raise a concern.

The registered manager told us she used a dependency scale to decide the appropriate staffing levels, although due to staff vacancies the provider had needed to use agency staff to cover the shifts. They told us this was an interim measure as they had a good response to the staff recruitment drive. The service had effective recruitment and selection processes in place. We looked at three staff files and saw completed application forms and appropriate checks had been undertaken before staff began work. Each had two references recorded and checks through the Disclosure and Barring Service (DBS). The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with people who used the service.

Good

Is the service effective?

Our findings

We looked at how people's health needs were met. Records showed us when appointments had been made and what advice had been given by medical professionals. People who lived at the home told us about times when they had asked to see a doctor and how staff had made arrangements. One person had confirmed to us, "They had seen the doctor, dentist and optician when they required." The registered manager confirmed they worked in partnership with the district nursing team as people needed.

Staff had received training which was relevant to their roles and this was kept updated. Staff told us they had received training that helped them to meet the specific needs of people they provided care and support to. We saw from the training records staff training was up-to date and many staff had completed their National Vocational Qualifications (NVQ) in care. Senior staff had completed specialist training in dementia care.

We spoke with one staff member about the induction procedures and how these supported staff when they started to work at the home. They told us this helped them to get to know people who they supported. For example they worked with other staff as part of the induction programme to help new staff to become confident when providing care. All staff spoken with felt supported in their roles by the management team and their colleagues. Staff told us they had one to one meetings which gave them the opportunity to discuss any concerns or issues they had, training they needed and to gain feedback about their own performance.

We saw staff asked for people's consent and offered people choices and explanations before care or support was provided. The people whose care we looked at all had recorded 'do not attempt resuscitation '(DNAR) decisions in place. These are plans where people decide in the event of cardiac arrest they do not want to be resuscitated. These had been reviewed and updated regularly to ensure that they remained relevant, up to date and in accordance with people's wishes

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 to 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 registered manager showed us the DoL applications she has made to the supervisory body because it was necessary to restrict some people's freedom of movement to keep them safe.

We saw a range of food and drink was available at the home and people with specialist diets were supported by the cook preparing specialist meals for people. Jugs of squash were available for people to help themselves throughout the day. However we saw from the daily notes the meals people eaten had been recorded but what people had drank had not Where people had fluid monitoring charts in place, entries were not consistently made. This made it difficult for staff to accurately measure how much people had drunk to make sure people's individual needs were responded to so risks of people becoming dehydrated were reduced.

Requires Improvement

Is the service caring?

Our findings

People told us staff were caring and they were happy living at the home. One person told us, "The staff are my friends." A relative said, "Care staff know [person's name] well, they are very caring." People and their relatives told us they were welcome to visit at any time. However during the inspection we saw people's right to confidentiality was not always protected. For example we saw throughout the inspection people's daily records containing personal information were left in the dining room for anyone in the home to read.

What we saw and heard showed staff practices that did not always reflect caring and dignity approaches when supporting people. We received a concern from a relative to say they thought their relative had not had a bath or shower for over a month, when we checked their care records we could not find any record of them having a bath or shower. We heard a member of staff call across the dining room "I've managed to shift [person's name] ". Another member of staff described someone suffering from dementia and anxiety as "Kicking off".

We spoke to staff about how they understood people's likes and dislikes and personal preferences, they told us they were recorded in people's care plans. However when we asked people if they were involved in their care plan one person told us they were aware they had a care plan but, "Never seen it or discussed the contents." Another person new to the home told us told us, "No formal care plan and I have not been asked about my preferences." A relative we spoke with told us, "No-one had discussed their relatives care plan with them or attended a review about the care and support their relative received".

People who were more independent were more likely to form positive relationships with staff and the staff understood their needs. Where people could walk around the home, we saw people laughing and chatting with staff. However where people had walking and communication difficulties there was a lack of staff interaction apart from when tasks with people were being undertaken. Throughout the inspection we saw people sat isolated in their rooms, or dining room, staff would walk past with little or no interactions or activities.

We spoke with the registered manager about access to advocacy services; we were shown minutes of meetings with the local advocacy service. They had supported people when they had no relatives to represent them.

Requires Improvement

Is the service responsive?

Our findings

During the inspection we spent time with people in the dining room to see people's experiences of how staff responded to their individual needs. Interaction between staff and people at the home during meal times did not always encourage people to eat and drink. We saw one member of staff was available and supported ten people in one of the dining rooms. Four people were asleep with their head on the dining room table, their meals was placed in front of them with little attention from staff to alert them it was there.

People could choose where they had their meals in their bedrooms or separate dining rooms. After thirty minutes of the meals being served we were approached by a relative to say two people had not been served lunch, the member of staff we approached apologised and rectified the situation. When we mentioned our observation to the registered manager, they thought the error may have occurred due to agency staff being on shift and inadvertently missed people. People told us they enjoyed their meals. One person told us "Breakfast is really good". Another person told us "The food is excellent; we get a choice of meat or vegetarian."

People we spoke with didn't always get the opportunity to follow their interests and do the things they liked. One person told us, "I used to go to the library once a month but I don't get to go any more." On the day of the inspection the activity co-ordinator was not available; no one was available to cover their duties. The staff told us usually the activities co-ordinator organised activities and interesting things for people to do. On the days of our inspections we didn't see any activities being offered as staff were busy engaged in care support duties.

We did see there were activities arranged throughout the following month such as yoga sessions weekly, music sessions fortnightly. We saw people asleep most of the day sat in the dining room and lounges with nothing doing to do apart from watching television. People sat in their own bedrooms, some still in bed with a lack of stimulation.

Staff who had been employed at the home for a number of years spoke with a good understanding of people's understanding of people's preferences, routines and care needs. We saw no such information was available in any great detail, in the care plans for all staff to read and follow.

When we spoke to some staff about people's routines, they could not tell us about people because they were agency staff and unfamiliar with people. For example, we saw staff being unsure of people's names, what sort of meal they required and how people liked to be cared for.

We saw the provider had a complaints policy in place. We saw that information about how to complain was accessible in the home. Staff we spoke with told us they knew how to respond if someone made a complaint. People we spoke with told us that they were happy with the care they received. They said they knew how to make a complaint if they wanted to. One person said, "I've no complaints." Another person said they had shared some concerns with the registered manager and they took action to resolve these.

When we spoke with the registered manager they showed us they had documentary evidence of the actions they had taken. One person gave us an example of how they had complained when they needed new flannels; the registered manager had replaced them immediately.

Requires Improvement

Is the service well-led?

Our findings

There was a system in place to assess and monitor the quality of the service. However, we found shortfalls, for example, areas of documentation including end of life care, daily records were not signed and charts were not always up to date. This was an area that required to be improved if people's health and well-being was to be monitored accurately; the registered manager acknowledged our findings and said it would be addressed as a matter of urgency with staff.

The registered manager showed us minutes of the six weekly meetings she had with the provider to discuss developments and actions she had made. They told us they felt supported by the provider in the management of the home. An example they gave us was after medication administration concerns the provider had agreed to fund the new medication system.

People we spoke with told us there was lack of management presence at the weekends. One relative told us, "It's seems at weekends no one seems to be in charge." We spoke to the registered manager about this who acknowledged there had been a recent change in staffing as the deputy manager had left. Senior staff were being requested to "act up" as care co-coordinators (team leaders) to take charge of the shift. This meant that if staff had required advice or support from someone senior, it may not have been available on site.

Due to staff vacancies the registered manager had needed to use agency staff, the registered manager told us this was an interim arrangement, whilst they waited for new staff to commence their employment. This is because they were attracting more experienced candidates for the vacant posts.

We asked people their opinions about the management of the home. People told us they liked the registered manager and felt they could approach them if they had a problem or concern. We saw the provider had policies and procedures where available for staff to support practice. There was a whistle blowing policy and staff were aware of their responsibility to report any bad practice.

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Relative and people quality feedback forms had been sent out in July 2015 and returned with some positive results, with the least positive being around activities. The registered manger had responded to this by arranging more activities and outings. Resident meetings had been held but only a few people had attended. The suggestions they had made had yet to be implemented because they requested more outings, but the registered manager told us they would take place in the warmer summer months.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was in breach of Regulation 12 (g) because people did not have their medicines administered and stored in a safe way.