Chasewood Care Limited

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Inspection report

Chasewood Lodge
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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 19 and 20 April 2016. The visit was unannounced on 19 April 2016 and we informed the provider we would return on 20 April 2016.

Chasewood Lodge Residential Home provides accommodation, personal care and support for up to 107 older people living with advanced dementia and physical frailty due to older age. At the time of the inspection 67 people lived at the home. The home has two floors; with four care units on each floor. The ground floor units are Blue-Bell, Fern Way, Poppy and Leaf Lane. The second floor units are Copperfield, Tulip, Holly Rise and Forget-me-not. Those people living on Leaf Lane had physical frailty due to older age as well as dementia.

The home is required to have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. At the time of this inspection the home had a registered manager; who had been in post since 1997.

At our previous inspection in November 2015, we found four breaches in the legal requirements and regulations associated with the Health and Social Care Act 2008. Breaches were found in the management of medicines, the safe care and treatment of people and people's consent to care and treatment. A breach in the good governance of the home resulted in enforcement action being taken and we served a warning notice on the provider and the registered manager. The home was placed in 'Special Measures.' The special measures framework is designed to ensure a timely and coordinated response where we judge the standard of care to be inadequate. Services in special measures are inspected again within six months.

At this inspection we looked to see if the provider and registered manager had responded to make the required improvements in the standard of care to meet the regulations. Whilst we found some areas of improvement had been made, we found no improvement to the management oversight to check that duties delegated to junior staff members had been carried out effectively, that we identified in November 2015. This meant that the requirements of the warning notices served on the provider and registered manager following our November 2015 inspection had not been fully complied with.

Risks around people's care were not managed consistently. Staff did not always have the skills, knowledge or training they needed to manage risks to people. People had their prescribed medicines available to them and improvement had been made in the safe storage and administration of medicines. However, further improvement was required in the safe management of people's 'when required' (PRN) medicines. Staff were not given adequate guidance on when to give PRN medicine and were not trained to administer one person's PRN medicine. Since the last inspection, staff had completed fire safety and fire aid training to deal with emergency situations that might arise, such as a person choking or in the event of a suspected fire.

Improvements had been made in gaining people's consent and staff worked within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Further training was planned for staff to give them a greater level of awareness about the act. Improvement had been made to people's Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) records and to inform staff which people had a DNACPR in place.

People said they enjoyed their food and we saw nutritious meals were available. Staff supported most people with their food and drink as required. Whilst people were referred to healthcare professionals when needed, improvement was needed in the communication of important ant information from staff about people to healthcare professionals.

Most staff showed a caring approach toward people they supported. However, we saw examples of when this could be improved to ensure people's dignity was respected.

People's care records were not person centred and staff had a limited knowledge about people so that their personal and individual needs were not always met. Some improvement had been made to offer social activities and further improvement was planned for with the recruitment of an activities staff member.

Systems to assess the quality of the service provided were not effective. We found there was no improvement to the management oversight to check delegated duties had been carried out effectively.

At the last comprehensive inspection in November 2015, this provider was placed into special measures by CQC. This inspection found on-going breaches of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014 and not enough improvement to take the provider out of special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

You can see what action we told the provider to take at the back of the full version of the 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

The service was not consistently safe.

People had their prescribed medicines available to them and improvements had been made to the safe storage of people's medicines. However, staff did not always have the information or training they needed to safely manage people's 'when required' medicines. Where people had been assessed at being at risk, this was not consistently managed and staff did not always have the knowledge about how to keep people safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Some improvement had been made to gaining people's consent and staff worked within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Further training was planned for staff to provide a greater depth of knowledge about the Act. People had sufficient food and drink and staff made referrals to healthcare professionals when needed. However, communication of important information was not always effective because staff did not have the details they needed to share with healthcare professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People and relatives told us that staff were kind and caring towards them. Some people experienced caring and respectful interactions from staff. However, this was not consistent and some people's dignity was not always maintained. People and their relatives were not routinely supported to express their views or be involved in decisions about their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Some people experienced positive responses from staff but this was not consistent and people did not always receive care that

was personalised to them. Improvement had not sufficiently been made to ensure people's care plans were detailed to support staff in delivering care in accordance with people's needs and preferences. Some social activities were offered to people with further plans in place for improvement.

Is the service well-led?

Inadequate

The service was not well led.

Some actions had been taken to improve, such as health and safety building assessments and care training for staff. However, sufficient improvement had not been made to the provider's systems to monitor the quality of the service provided to ensure that these were effective. This meant that a number of shortfalls continued in relation to the service people received that had not been identified.

Chasewood Care Limited

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.

The inspection took place on 19 and 20 April 2016. The visit was unannounced on 19 April 2016 and we told the provider we would return on 20 April 2016. The inspection team consisted of two inspectors and a pharmacist inspector and an expert by experience on day one. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of care service. On day two, two inspectors returned to continue the inspection.

We reviewed the information we held about the service. This included information shared with us by the local authority and statutory notifications received from the provider about, for example, deaths that had occurred at the home. A statutory notification is information about important events which the provider is required to send us by law. The local authority imposed a placement stop on the provider on 12 February 2016. This meant that the provider was not permitted to admit any further people to live at the home. The Environmental Health Officer (EHO) shared an Improvement Notice with us that had been served on the provider on 18 December 2015, for environmental health and safety improvements that were legally required at the home.

Most of the people living at the home were not able to tell us about how they were cared for due to living with dementia. We spent time with them and observed the care and support they received from staff.

We spoke with seven people and spent time with other people on all the units within the home. We spoke with 11 relatives who told us about their own and family members' experiences of the service. We spoke with staff on duty including 15 care staff, one cook, one laundry assistant, the registered manager and the provider. We spent time with and observed care staff offering care and support in communal areas of the home. We received feedback from two visiting district nurses and ambulance crew that had attended the home.

We reviewed a range of records, these included care records for 10 people and 25 people's medicine administration records. We reviewed two staff induction and employment records, staff training and quality assurance audits and minutes of staff team meetings.

Requires Improvement

Is the service safe?

Our findings

In November 2015, we identified a breach in the regulations regarding the provision of safe care and treatment. Although risk assessments had been undertaken, we found they lacked detailed information about what actions staff should take to reduce the risk of harm or injury to people. At this inspection we looked to see if improvements had been made. We found some improvement had been made, however further improvement was still needed to meet the regulation. We found that risks around people's care were not consistently managed. Further improvement was needed to ensure risks to people were fully assessed and actions identified to reduce the risk of injury. Improvement was still needed to ensure staff had the information available to them so that they could implement the actions needed to maintain people's safety.

Specific individual risks had not always been identified and were not managed consistently by staff because they did not have the information they needed. For example, one person had a mental health diagnosis and had demonstrated behaviours that challenged them and others. This meant that they and other people living at the home, and staff members, were at risk of harm or injury. No behavioural management care plan or risk assessment was in place for staff to follow so they could support this person when they became upset, distressed or agitated. We discussed how this person's behaviour was managed with senior carers and their responses were inconsistent. One senior carer told us, "What we try and do is take [Person's Name] to a quieter area; using a wheelchair, they prefer that. If we couldn't talk them down, I give their medicine to them." Another senior carer said, 'Anything could trigger the person's behaviours, you just sit and talk to them and take them for a walk around the corridors. Just chat with them really to calm them down." We found that this person's inconsistently received their PRN medicine from staff and their behaviours were inconsistently managed because staff did not have the information they needed.

Another person's care plan recorded that a behavioural risk had been identified which may place female residents and female staff at risk. Their behavioural management care plan told staff to 'record and report' instances that occurred and to monitor the person at all times and their whereabouts. We found no risk assessment to tell staff what action to take to avoid the behaviour escalating or what action to take to manage any displays of this behaviour. When we asked staff if any of the people living at the home might display such behaviours, staff did not identify the person. The person's care record stated they moved independently around the home which meant they were not monitored at all times and staff were unaware they needed to monitor this person.

Some actions had been taken to reduce the risk of injury to people identified at risk of falling. Staff told us some people had pressure sensor mats next to their bed; so that in the event of a person stepping out of bed, the mat triggered the call bell so that staff could go to their bedroom to support them. Other people had a soft mattress placed next to their bed and one staff member told us, "We use those as 'crash mats' in case the person rolls out of bed."

The registered manager told us some staff had completed 'train the trainer' in moving and handling. This meant that they were able to train other staff to safely move and transfer people. One staff member told us,

"If I saw poor moving and handling I would intervene." We observed two staff members supporting one person to stand and walk at different times; they each used different techniques to support the person. The person was living with dementia and identified as being 'at risk' of falling, but no guidance was available for staff to refer to as to how support should be provided. We observed different staff supporting this person to stand and saw staff used different techniques and were inconsistent in the support given. This person was confused and unsteady whilst standing as they appeared unsure about the guidance given to them. We discussed this with one senior staff member; trained as a moving and handling trainer, and found they had not identified the inconsistent approaches used by staff.

One person complained to us, "Staff have put sugar in my coffee, I never have sugar. I can't drink that." We observed that most people on the unit were unable to verbally communicate their needs to staff and some staff member's knowledge was limited about the people they supported. Two staff told us they did not often work on that unit and were unable to tell us about people's needs. Some staff, on different units, were unable to tell us which size hoist sling individual people used. One person had their own named hoist sling but other hoist slings were shared between people and staff were unsure of which they should use. People's moving and handling risk assessments did not tell staff which size hoist sling to use. Two people's care records were confusing as different types of hoist were referred to. For example, one person's record told staff to use a 'stand aid' hoist but later said this person required a full body 'oxford' hoist. One staff member told us they believed the information was out of date. This meant accurate information was not available for staff to refer to when needed and the management of risks to people when being supported to transfer was not consistently safe.

This was a continued breach of Regulation 12 (1) (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we inspected the home in November 2015 we identified an ongoing breach in the regulations relating to the safe management of people's medicines. In November 2015, we found medicines were not always stored safely or securely. Medicines had been recorded by staff as given but we saw the medicines were still in the monitored dose system packs. Guidance had not been sought from a pharmacist to ensure that it was safe for medicines to be crushed and there was a lack of guidance to staff about when 'when required' (PRN) medicines' should be offered or given to people and staff were unable to locate some records requested by us. At this inspection we looked to see if the required improvements had been made to meet the regulation. We found improvement had been made to the safe storage of people's medicines and people's medicines were administered safely to them. However, improvement had not been made in the guidance and training for staff to safely manage people's PRN medicines.

Some people had medicine prescribed to be given as they needed them. For example, paracetamol for pain relief or first aid medicine following an epileptic seizure. People's medicine administration records (MAR) recorded times and dosages of these medicines were given to people. However, guidance to staff about when they should be offered or given to people was not always available or lacked detail. We had previously informed the provider and the manager that improvement was needed in our previous inspections during November 2015 and November 2014. During this inspection we found whilst the registered manager had obtained 'PRN protocol' forms, sufficient improvements had not been made to the information available to staff.

For example, one person's guidance for their PRN medicine stated it was for 'agitation.' When we asked staff about how they managed the person's 'agitation' they were inconsistent. The person's MAR showed they were being given the medicine every day and up to four times a day which was more frequently than they should have been given it. This indicated that staff were not supporting this person's mental health needs to

minimise the risks. The frequent use of the medicine had not been identified by the provider's audit and no review had been requested from the person's GP. We discussed the person's 'when required' guidance with the registered manager and they said, "It is not adequate, it doesn't give any detail." However, they did not tell us they would address the issue.

Another person was prescribed a first aid medicine for epileptic seizures. We asked a senior carer who was trained to administered people's medicines what they would do if the person had a seizure and they told us, "I would call a first aider, who would assess the situation. If we could not calm them, we would call the paramedics." The senior staff member told us the person was given their daily prescribed medicine for epilepsy but was not aware of the prescribed first aid medicine. The person's medicine care plan stated it should be "given if a seizure lasts for more than ten minutes" but gave no guidance to staff about the person's epilepsy or managing their seizures. Three staff members told us they had observed the person having a seizure and were inconsistent in telling us how they managed them and were not aware of the first aid medicine. We found that staff had not received training in how to meet the needs of a person with epilepsy and did not have the knowledge they needed to safely administer the person's prescribed first aid medicine.

One senior carer told us, "We do the audits and give them to the manager." Senior carers told us they counted people's medicines as part of a check on the safe management and administration of medicines on a weekly basis. However, the checks in place had not identified the medicine safety concerns we identified.

Staff told us how medicines were obtained and we saw that people had their prescribed medicines available to them. We found that improvements had been made in the way that the medicines were managed and stored safely, such as within the correct temperature control limits.

We observed senior care staff administering people's medicine to them and found improvement had been made. Staff wore a tabard to inform other staff they were administering medicines and should not be disturbed, one staff member told us, "It helps minimise distractions so we can concentrate." Staff treated people respectfully when they supported them to take their medicine and we observed that staff followed safe practice skills from their training. Staff completed people's medicine administration record after administering medicines which we found accurately recorded that people had been given their medicines at the right time.

Three people were given their medicines 'covertly'. Covert administration is where medicines are given to people without their knowledge and mixed with their food or drink. We found some improvement had been made in obtaining and recording guidance given from a pharmacist about the stability of the medicines being crushed for two of the three people. However, we found that one of the third person's medicines, where staff told us pharmacy advice had not been sought, should not have been crushed. There was no documentation available to warn staff about potential risks. Further improvement was needed to ensure guidance, from a pharmacist, was sought so that staff had the information they needed and so that the registered manager undertook necessary risk assessments in the safe handling of people's medicines.

Staff were aware of the importance of maintaining a safe environment for people to live in and this included comments to us, such as 'making sure things were not on the floor so that people did not trip over them.' One staff member said, "Some people like to carry a blanket over their walking frame, so when we help them to walk, we have to make sure the blanket is not dragging on the floor otherwise they might fall over."

Relatives told us they felt their family member was safe living at the home and staff protected them from abuse. One relative told us, "There are always staff around, they are safe living here." Staff could tell us what

abuse was and said they would report any concerns to the manager.

Relatives and staff told us they felt there were enough staff on shift to meet people's needs. One staff member said, "If someone is off sick, then the senior carer will phone to see if anyone else can come in to cover. The management don't use agency care workers here. Usually one of the staff will pick up the shift. I'd say we have enough staff each shift." We observed there were adequate numbers of staff on shift. However, improvement was needed to ensure staff allocated to different units had the information about people available to them so that their support and care was safety provided.

Further improvement had been made to staff employment records. One recently appointed member of staff told us, "Before I started working here, I came for a look around and then applied and had an interview. I think they did some checks before I started working with people." We looked at two staff employment records and found they were complete and documented checks that had been completed.

Improvement had been made in how staff said they would deal with emergencies, for example a person choking on their food or the fire alarm sounding. Staff told us they had completed further first aid and fire safety training. One senior staff member explained that the registered manager used a notice board to identify a first aider and fire marshal shift member for each floor of the home every shift. They said, "This is better, it means one person will take control for each floor." Most staff responses, when asked about dealing with emergencies, were consistent and said they would follow the instructions of the allocated staff member or the emergency services when they arrived. People had personal emergency evacuation plans that were more detailed; we saw these were up to date and located so that they could be handed to emergency services in the event of a fire.

During our inspection in November 2015, we had noted some areas of the home were in need of maintenance and planned work had not been completed since our previous inspection in 2014. The provider told us, during our November 2015 inspection, that these were planned for and would be completed by January 2016. However, we found some planned maintenance issues had not taken place. For example, cupboard doors in the communal lounge kitchenette areas had either no seal or peeling seals. This meant areas could not be cleaned properly and was an infection control risk. The plastic seal cover of one communal toilet seat was damaged. We discussed these issues with the registered manager and provider. The provider told us, "We've had to prioritise as lots of things needed doing. We have done a few things but didn't manage to get everything done as planned for by January 2016, but things will be done as needed by May 2016."

Requires Improvement

Is the service effective?

Our findings

When we inspected the home in November 2015 we identified a breach in the regulations regarding peoples' consent to care and treatment and that was not always sought in line with the requirements of the Mental Capacity Act 2005. At this visit, we found some improvement had been made and further improvement was planned for.

Relatives told us they were aware of the use of Closed Circuit Television (CCTV) in communal areas of the home. Signage was displayed to inform people entering the home and also within the home stating the CCTV was in use for people's health and safety. The registered manager informed us that the information guide about the home was planned to be updated to include information about the use of CCTV in the home.

Some staff told us they had completed training on the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 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 are called the Deprivation of Liberty Safeguards.

One staff member told us, "I always explain to people what is happening, we can't force people to do things." We observed staff worked within the principles of the Act and whilst not all staff had received training on the MCA or DoLS, we saw staff asked people's consent and explained to people what was happening. For example, we saw staff asked people if they could help them to the table. The registered manager informed us that further training for staff was planned for May 2016.

The home had key-coded doors and access out of the home was restricted to the staff team who knew the code. Staff confirmed to us that the locked door was for both security and to prevent people from leaving the building. We asked staff which people had a DoLS in place. One staff member said, "A few people here have." Another staff member said, "I think everyone has." The registered manager informed us that for those people living at the home that did not already have an authorised DoLS, they had made DoLS referrals to the local authority. They said that the local authority were currently in the process of authorising these for people that met the criteria in line with the Act.

The registered manager informed us that they had considered different ways of keeping staff informed about which people had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place. They had introduced a 'wristband' scheme similar to those used in hospitals; where people, with the consent of their relatives, wore a discreet wristband that identified they had a DNACPR in place. Peoples' care records confirmed DNACPRs were in place in consultation with their GP. Where the person themselves, due to their complex health needs, had been unable to consent to wearing the wristband, their relatives had been

consulted. Staff told us they were aware of the wristbands being introduced and knew what they meant. One senior carer told us, "Anyone with a DNACPR should be wearing a wristband. If we needed to call an ambulance, we would give the paramedics the person's care file which has their DNACPR form in it." This meant that improvement had been made to staff having the information they needed to ensure the right course of action was followed.

One staff member told us, "I'd never done care work before and started here this year. I had an induction and have done some training. I've got some more to do. I did the dementia awareness this morning. I thought it was really good and it explained about diverting people's attention if they are getting anxious about something." Some staff had worked at the home for several years and told us they had completed core training, such as health and safety and moving and handling . One staff member said, "I've done quite a bit of training, but think there are still some areas I need more on but I know the manager has some more planned for us."

Staff told us they felt supported by senior care staff and felt they could approach them if unsure about anything. Staff told us they had team meetings with the registered manager but most staff could not recall one to one supervision meetings. The registered manager explained that planned improvements to supervision had not been fully implemented due to both deputy managers leaving the home. Staff said they felt supported within the team and received peer support. One staff member said, "The manager always has a walk about the home each day." We found that whilst the registered manager did complete a daily walk about the home, further improvement was needed in the leadership of the staff team to ensure staff effectively implemented skills and knowledge from training to provide best practice care to people.

People said they enjoyed their food. One person told us, "We get plenty of food here. I'm pleased with what I have. I don't think they give me a choice, but the staff know what I like. I have no complaints about the food." The cook showed us information they had about people's preferences and told us, "Some people have special diets because of their health, such as diabetic diets. We also cater for different cultural food likes".

People were offered sufficient food and drink. Some people were assessed as being at risk of malnutrition and / or dehydration and depended on staff assisting them to meet their nutritional needs. One staff member told us, "Some people eat very slowly so we have a staggered mealtime, with soft food diets coming to the unit first." Whilst we observed most people were offered the support they needed, we saw one person who walked away from their meal several times. This person was guided back to the table by staff, however the staff member did not stay in the dining area to prompt and offer the support that the person's care record said they needed. We observed this person did not eat their meal. We discussed this with the two staff members on the unit and they said they had to support other people with their meals in their bedrooms. One staff member said, "We try to pop back into the lounge to check people when we can."

Relatives spoken with felt confident that staff would ask for a GP visit if their family member was unwell. One relative said, "My family member can longer speak but I know staff check on them often and would call a doctor if needed." Senior care staff told us if they thought someone was unwell they would arrange for a GP visit. Healthcare professionals told us that improvement was needed in the information that staff had to share with them about people, such as their medical history. Ambulance crew informed us staff had recently not been able to inform them about important information about one person they needed to take to hospital when they were unwell. One district nurse told us, "Some staff are very knowledgeable and can tell us what we need to know such as whether a person has been eating and drinking well, but other staff say they don't know and we don't have the information we need. Communication could be improved upon greatly." We found people were supported to maintain their health and received visits from healthcare

professionals when needed, however, improvement was needed in staff communication about people's wellbeing to healthcare professionals.

Requires Improvement

Is the service caring?

Our findings

Relatives told us they believed their family member were well cared for by staff. One relative said, "My relative is being looked after well here; I'm happy with the staff and management." Another relative said, "Staff are very caring and supportive." A further family member told us, "The staff are wonderful and caring. When I wanted to take my family member out, the staff advised me it might be difficult for me, so they arranged for us to have a quiet room where we had a romantic meal together."

We observed some kind, respectful and friendly interactions between staff and people living in the home. Staff greeted people by their preferred name and spoke with them and listened to people's responses. A few people enjoyed helping with tasks, for example one staff member gave the salt and pepper pots to one person so that they could place them on the dining table.

People living at the home could not recall being involved in decisions about their care. However, a few relatives told us they had been invited to reviews about their family member's care and support. One relative told us, "Last year I was invited to a review when we could say if we were happy with the care. We said everything was okay." Other relatives told us they had never heard about any care reviews. The registered manager informed us that they had displayed a sign close to the front entrance asking relatives to contact them if they wished to have a care review and be involved in making decisions about their family member's care. Although we saw this was displayed, it had not always been effective in informing people's relatives. The manager did not inform us of other ways they had encouraged and supported relatives to attend people's care reviews. Some relatives were unaware of the process of needing to contact the manager if they wished to be a part of making decisions about their family member's care.

We received mixed responses from relatives about how staff promoted and maintained people's dignity and we saw there was an inconsistent approach by staff resulting in people having mixed experiences. One relative told us, "Staff keep my family member spotlessly clean." Another relative said, "My family member is always nice and clean." However, a further relative told us, "There needs to be more focus on cleanliness; personal care and bedding. My family member's hair is not combed, clothes are dirty. It looks very bad." Whilst we observed most people were well presented we did see a few people whose needs had not been met.

During one mealtime, we saw some staff stood over people to support them with their meal and had not considered how their actions were impacting upon people's dignity. Another person sat with their blouse undone through lunch; for 30 minutes, until a staff member noticed and re-buttoned it for them. One person had long and dirty fingernails and we saw they used their fingers to eat their food. Staff did not cleanse the person's hands before or after their meal. Another person had long finger nails that were digging into their skin on the palm of their hand that they held tightly together. We mentioned this to a staff member and they told us, "I don't support [Person's Name] with personal care." They did not tell us they would ensure another staff member was informed so that the person's nail could be trimmed and on day two of our visit, we saw the person's nails had not been trimmed.

One person shouted out that their trousers were 'wet' and a staff member went to the person and quietly suggested they go with them to their bedroom where they supported the person to change their clothing. One staff member said, "I knock on people's doors even though they can't answer back, I think it's polite." We observed staff did this and said who they were as they entered which showed they respected people's privacy.

We saw signage on one person's bedroom wall telling staff not to turn their radio to pop music otherwise they would face disciplinary action; this had been written and put up by the registered manager. This did not promote a friendly environment in that person's bedroom or promote their dignity. We discussed this with the registered manager and they said, "I see your point about dignity for the person."

Requires Improvement

Is the service responsive?

Our findings

One relative told us, "I am happy because the home has staff that can communicate with my family member in their first language which is not English. My family member prefers to stay in their bedroom and staff respond to that and check on them every so often."

We saw some positive responses from staff toward people that was personalised to their needs, however, our observations showed inconsistencies in how staff responded. For example, one person was anxious because their watch was not working. One staff member attempted to mend it, but was unable to do so, and reassured the person they would arrange to take them to town to get it mended. This message was handed over to other staff so that a consistent message was given to the person in response to their anxiety about their watch. One staff member took two people outside for a short walk and fresh air and told us, "These two ladies enjoy a short walk outside; it helps to settle them for the morning."

However, we also saw examples where people's needs were not met. For example, one person was struggling to eat their hot meal, served with gravy; with a fork they had been given. We asked a staff member if they often struggled with a fork and they told us they did. We asked if they had considered offering the person a spoon and they told us, "No, we give them a knife and fork but sometimes they use their hands. But, I can try a spoon if you think it might be better." We saw the person was able to use the spoon to independently enjoy their meal. We saw another person's care record stated they 'struggled with cutlery and now had a 'finger food diet'. However, we saw they were served a meal with peas and diced carrots. No consideration had been given by staff as to how they could eat the meal with their fingers. We found specialist equipment such as adapted cutlery was not available and one staff member told us this had not been considered for the person prior to the decision of them having a 'finger food diet'.

When we asked staff about people's needs, some staff said they did not know people well enough to tell us. One staff member said, "I don't usually work on this unit, so I can't really say what people's needs are or their likes or dislikes." We discussed this with the manager and they said, "Staff work across all units and should know people. I do try to use staff consistently in some units and some staff do have a preference as to which unit they work on, but they should still know the different units. If they are unsure, they know they should look at the person's care plan. We do have training on today, so that may be why some staff are not as familiar with people they are supporting as they may be working with different people."

Care plans seen were not personalised. Although people's care plans briefly described most people's needs, the information was not detailed and did not always inform staff how to meet needs in a way the person preferred. We found little information about people's likes, dislikes, routine or preferences which meant staff did not have the information to refer to if needed.

During our last inspection in November 2015, we identified that a number of people were cared for in their bedrooms and had no call bell cord accessible to them. We were told they might not be able to use them but found there had been no assessment of people's ability. At this inspection, one person told us, "We now have a call bell. We can press it if we need staff." However, we found most people cared for in their

bedrooms still did not have a call bell cord accessible to them and their ability had not been assessed. Staff informed us that people were checked every two hours in their bedrooms to support them with any care needs and we saw staff did this.

One relative told us, "Activities have started to take place." Staff said activities for people had improved and one staff member said, "Before the last inspection you did (November 2015) we never had activities for people, but now more are taking place." Although we observed limited activities over the two days of our visit, some took place. People were asked if they would like to join a 'sing along' activity on day two of our inspection and we saw one staff member play soft ball catch with a person. We observed some staff took opportunities to sit and talk with people. The manager informed us they had recruited a staff member to provide activities for people at the home. The registered manager told us, "I just need to arrange a start date for the new staff member and they will do 14 hours a week of activities. We also have weekly things happening like the hairdresser visits and on occasions we organise events like a singer visiting. Staff also fit in activities when care tasks are completed." We found some improvement had been made and further improvement was planned for with the appointment of an activities staff member.

People and their relatives told us they had not contributed to the initial planning of their care. We received mixed responses from relatives about whether they were asked for feedback on their experience of using the service. Some relatives said they had been invited to attend a care review and were asked if they were happy with their family member's care, but others said they had not been invited to a review or asked for feedback on the quality of care. None of the relatives were aware of any relative meetings or any other way they could give feedback. The manager told us if relatives contacted them, they would be happy to meet and receive feedback. We found relatives experiences of being asked for feedback was inconsistent which meant that opportunities to learn from people's experiences may have been missed.

We asked people and relatives about what they would do if they wanted to raise a concern or were unhappy about an aspect of the home. Relatives told us they would complain to the registered manager if they felt they needed to. One relative said, "I've got no concerns. If I had, I'd raise it with the manager." The registered manager told us they had received no recent complaints.

Inadequate

Is the service well-led?

Our findings

When we inspected the home in November 2015 we identified a breach in the regulation relating to good governance of the home. We found planned improvements; following our previous inspection in November 2015 had not been fully implemented with insufficient improvements made. We found a number of examples during the two inspection days which had not been identified by the registered manager or the provider from their own audit processes which meant the provider's audits to monitor the quality of the service provided were still ineffective. We served a warning notice on the provider and the registered manager and placed the home in 'Special Measures' and the home was rated 'inadequate.'

On day one of this inspection, we saw that the provider was not displaying their CQC rating in the home; from our November 2015 inspection. It is a regulation, which came into force on 1 April 2015, that says providers must 'conspicuously' and 'legibly' display their CQC rating at their premises and on their website. We looked at the provider's website the day before this inspection and found it did not include details of the home's CQC rating. We discussed this with the registered manager and they told us, "We didn't know we had to do this. I'll do it if it is something we need to do. An external person does the website for us; we'll have to tell them." The provider told us they were not aware of the requirement to display their rating. On day two of our inspection, we saw a poster was displayed to show the rating of the home.

At this inspection, we looked to see if the required action had been implemented to meet the regulations. We found some action to improve had been taken such as environmental health and safety issues. For example, an asbestos survey and a legionella assessment plan had been completed by external professionals. Training for staff, such as fire safety and first aid had taken place and further training was planned for. However, we found insufficient action had been taken to improve the systems and processes to effectively monitor and assess the quality of the service and provide effective leadership and oversight of delegated tasks. Some training needs of staff had not been identified such as the safe technique to administer one person's first aid medicine.

The registered manager informed us that since our last inspection there had been changes to the management structure which now consisted of themselves and the provider. One deputy manager had left in November 2015 and the other in January 2016. The manager said, "We did advertise, but did not have much response. Also, we don't want to rush into making a wrong decision. We plan to advertise again soon." There were no administrative staff at the home and senior carers had scheduled 'office' days to complete administrative jobs such as putting together new staff files which took them away from the caring aspects of their roles. The manager told us that they were considering an administrative role for the home. The registered manager continued to manage another home as well but said, "Most of my time is spent at this home; I'd say 80% of my working week is at Chasewood Lodge."

We discussed the management of the home with the provider and they told us, "After the last inspection we sat down to discuss the failings. I'm responsible for the general maintenance and the manager is responsible for the care of people. We've put the failings right. We've had to prioritise and some more things will be done in May 2016." The provider added that, "The manager's leadership is excellent. They are firm but

fair. We are looking to get a consultant to help us with further training such as in medication administration and also with the audits. We have meetings planned later this week, with two different people to discuss these issues."

One person told us, "I know who the manager is; she is very kind and is walking about now." Staff confirmed that the manager and provider were at the home most days. One staff member said, "The manager always has a walk and look around every day. I think they do a good job."
Whilst some staff felt supported by the registered manager, others did not and felt she was not approachable. We found senior carers did not always have the information, skills or training they needed to deliver high quality care and provide guidance to other care staff.

We asked if there was on-call management support to staff in the evenings, nights or weekends. One senior carer told us, "Most seniors do on call now; since the deputy managers left." Another senior carer said, "There might be an occasion when there are no senior carers on a night shift, that's not often but in that situation the carer could phone us if someone was poorly and we could tell them what to do." We asked them if they had received any training or guidance about on-call support role and they told us they had not. We asked if they recorded any calls made to them or guidance given to staff and were told they had not been asked to make any record of on-call guidance. The registered manager told us that if needed senior staff could always telephone her if needed. However, staff experience in contacting the manager when needed was inconsistent. One staff member told us, "We can always call the manager" but another staff member said, "Sometimes if you need something, you can't always get hold of them."

We discussed issues, such as a lack of information about people's needs and how staff should meet these with the registered manager. They informed us that they had delegated reviews and audits of people's care plans to both senior and junior care staff, since the last inspection. They said, "Seniors have two files each to do and junior carers have one to do," and staff confirmed this to us. The registered manager told us that they had not checked reviews and audits completed by staff.

Whilst individual accidents and incidents were recorded by staff with a monthly total for each unit of the home, we found no overall analysis of accidents took place. 23 accidents were recorded for February 2016, with 12 people; we found this to be a high number. Action had been taken by staff for one person. We found when people had falls, no review of their falls risk assessment had taken place to consider whether actions were needed to reduce the risks of reoccurrence of falls. The manager told us, "No improvement has been made yet to introduce any analysis, that's in part due to the deputy managers leaving and the provider and I having to manage everything else." The lack of improvement meant that no consideration had been given as to how the overall number of accidents could be reduced through actions to reduce the risk of reoccurrence, and to keep people safe.

The same quality assurance processes were in place as we found at our last inspection in November 2015. We found these were not effective as audits delegated to care staff and had not been overseen by the registered manager. We found audits of the medicine management processes had not identified the issues we found at this inspection, such as risks around the safe management of people's 'when required' medicines and risks to staff when handling one person's covert medicine. The manager informed us that checks on staff competency in administering people's medicines did not take place. They said, "With the deputies leaving, this is something that was planned for, but has not yet started."

We were shown infection control audits and saw that these had been completed by the deputy manager of the provider's other home. The manager explained that they delegated the infection control audits for Chasewood Lodge to them because these audits had previously been allocated to the deputy of Chasewood

Lodge that had left. We looked at audits completed in February and March 2016 and found they had not identified issues that we found, such as, a cracked communal toilet seat, broken seals on work surfaces, cobwebs and dirt and missing cupboard- back panels in one kitchenette. These issues presented risks of cross infection that audits had not identified. We found other issues, such as broken light fittings above people's beds, showing a general poor maintenance of the home. There was no evidence to show us the registered manager checked audits to ensure they were an accurate reflection of the home. The registered manager said, "We really need a good consultant that we can delegate audits to. This is what the provider and I are currently looking at arranging."

The registered manager informed us they held relative meetings at the home as a way of consulting and seeking feedback from people's relatives. However, most relatives said they were not aware of these meetings. The manager told us feedback had been sought from people, relatives, healthcare professionals and staff during January 2016 and 25% of surveys had been returned. We looked at completed feedback and saw comments included, "friendly staff," "standards not as good as they used to be" and several comments about, "having to wait too long for the front door to be opened." Key points had been identified from the feedback but action points, such as plans to purchase new quilt covers and an updating the service user guide, had no timescale for implementation. The manager told us the information had been sent to an external consultant so that a 'pie chart' could be created and action implemented. This meant some improvement had been made with feedback sought from people, however actions to improve did not have timescales and were not allocated to individuals to implement. There was no check made by the registered manager to see whether improvement had been implemented.

This was a continued breach of Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not doing all that was reasonably practicable to mitigate risks regarding safe care and treatment of people. This was a continued breach of Regulation 12 (1) (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not operated effectively to ensure compliance with the requirements to assess, monitor and improve the quality and safety of the services provided. This was a continued breach of Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Positive Condition imposed