HC-One Limited

Chaseview Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 24 March 2016. Breaches of legal requirements were found including After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this focused inspection on 26 October 2016 to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Chaseview Nursing Home on our website at www.cqc.org.

Chaseview Nursing home provides accommodation, personal and nursing care for up to 60 people. At the time of our inspection there were 56 people living in the home.

There was 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 2008 and associated Regulations about how the service is run.

Staffing levels were at times insufficient to keep people safe and meet their needs. This was an ongoing concern following our last inspection. Relatives and staff did not feel their views about the number of staff available were listened to. People's medicines were not always provided at the times they were prescribed and staff were not provided with guidance about some 'as and when required' medicines to ensure they were administered safely.

Some incidents where people had been at risk of abuse or poor care had not been reported or discussed externally as required. Some people's freedom of movement was being restricted and causing them distress without the necessary legal permissions in place. Information about recent accidents was not readily available which demonstrated that communication within the home was not effective.

People's risks had been assessed but the management plans did not always reflect the care they received to keep them safe.

People who lacked capacity to make decisions for themselves were supported by staff however the reasoning behind decisions made in their best interest was not always demonstrated. The provider had not met their own action plan in respect of mental capacity assessments and deprivation of liberty applications.

It was not clear what actions had been taken in response to shortfalls identified during the provider's quality monitoring audits.

Staff were suitably recruited and received training to provide them with the skills they required to care for

people. People were provided with a choice of food and drinks were offered regularly. People's wellbeing was supported by healthcare professionals whenever addition guidance was required. People were asked for their views on plans for their future entertainment.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the back 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?

Inadequate

The service was not safe.
Staff were not given time to give people the care they need or to respond to emergencies or incidents. People were at risk because they did not always receive their medicines in the way they were prescribed. Incidents involving abuse or poor practice were not always reported or discussed externally as is required. Some people were being deprived of their liberty without legal authority. People's risks had been assessed but some people did not receive the care planned for them. There was a recruitment process in place to ensure staff were suitable to work in a caring environment.

Is the service effective?

Requires Improvement

The service was not always effective.
Staff did not understand the legal requirements for gaining consent and supporting people to make decisions. People were provided with a choice of food and drinks. Staff received training to provide them with the skills they needed to care for people. People had access to other healthcare professionals to support their wellbeing.

Is the service well-led?

Requires Improvement

The service was not always well-led.
Relatives and staff did not feel their concerns about staffing levels and the effect on people's care were listened to. People's confidential information was not protected. Quality monitoring shortfalls were not always followed up. People were provided with opportunities to discuss improvements.

Chaseview Nursing Home

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Chaseview Nursing Home on 26 October 2016. The inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 24 March 2016 had been made. We inspected the service against three of the five questions we ask about services: is the service safe, is the service effective and is the service well-led? This is because the service was not meeting some legal requirements. This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Chaseview Nursing Home on our website at www.cqc.org.uk.

This inspection was undertaken by three inspectors.

We looked at the information we held about the service and the provider including notifications they had sent us about significant events at the home. On this occasion, we had not asked the provider to send us a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they
plan to make. However, we offered the provider the opportunity to share information they felt was relevant.

We spoke with five people who used the service, 13 relatives, nine members of the care staff, two visiting healthcare professionals and the registered manager. We spent time observing care in the communal areas of the home to see how staff interacted and supported people who used the service.

We also looked at the care plans for ten people to see if they accurately reflected the care people received and other information related to the management of the home including recruitment files.

Inadequate

Is the service safe?

Our findings

At our comprehensive inspection on 23 March 2016 we judged there were insufficient staff available to meet people needs. Following our last inspection we received an action plan from the provider which stated they had reviewed people's dependency levels and found that no increase in staffing was required. They also planned to amend how they deployed their staff within the home to ensure there were adequate staff available to meet people's needs.

At the focused inspection on 26 October 2016 we judged that there were still insufficient staff to maintain people's safety and support their personal needs and preferences in a timely manner. Following our last inspection we continued to receive information from relatives stating that there had been no improvement in staffing levels and the impact this had on people's care and welfare. During our focused inspection one person told us, "I'm waiting to get up. I don't have a buzzer to press if I need anyone, I just wait. I like to get up straight after breakfast but it's sometimes lunchtime. I guess they're doing other people first. It's lonely in my room". A relative told us, "I have to ask for my relation to have a shower because staff just don't have time". A member of staff told us, "We have had more residents in the last couple of weeks and they have taken on more staff but it's still not enough". Another member of staff said, "I've been told they only take on more staff when the occupancy increases". The registered manager told us that an additional member of staff had been employed when the occupancy levels at the home had increased. This meant that the introduction of an additional member of staff had been related to the number of people who used the service. There was no evidence to demonstrate that people's changing care needs had been considered.

Relatives told us they regularly observed the care staff and felt they were kind and doing the very best they could, but had been given an unachievable work load. One relative commented, "There used to be far more staff available. I can't understand why there aren't as many now"? We saw that people sitting in the lounges on the ground floor, who required support from two members of staff had to wait for support with their personal needs. For example we saw one person requested the support of staff but had to wait for 25 minutes for two members of staff to be available to support them.

A relative told us, "I come in everyday because I worry that my relation won't be safe otherwise". We saw two members of staff using equipment to move a person from their chair in the lounge to a wheelchair. Two members of staff were required to complete this manoeuvre safely. At the same time a person who required support to mobilise was seen attempting to move from their chair in the same lounge but was at risk of falling if they walked without support. We heard another person shouting for help from the corridor outside of the lounge. There were no other staff available to support all of these people at the same time which meant people were at increased risk of falling.

We observed the support people received at lunchtime and saw, in one of the dining rooms that there were not enough staff to support people to have a relaxed and enjoyable meal. A relative told us, "I come in at mealtimes to make sure my relation gets their meal". In this dining room we saw there was only one member of staff available to assist four people which meant that rather than having the opportunity to sit with people they had to move between people offering assistance on an 'as hoc' basis. We saw that some

people did not finish their drinks as they had become cold because staff had not had time to support them whist their drink was still hot. This meant people were potentially at risk of dehydration.

Staff told us that since our last inspection a member of care staff had been allocated to maintain a presence in the communal sitting room on the first floor. Staff said this had impacted on the number of staff available to provide care to people in their room. One member of staff told us, "We just don't have enough staff. People have to wait for their care". Another member of staff said, "On a good day we can get everyone up by lunchtime but on a bad day it could be teatime".

The above evidence shows that staff were not always available to keep people safe or meet people's care needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some incidents which had occurred in the home met the criteria for a safeguarding referral but had not been reported as required. Prior to our inspection we had received information from the police regarding a safeguarding incident they had been asked to attend. The registered manager had not informed us of this incident which they are required to do as part of their registration conditions. We also found during the inspection that two incidents of alleged physical abuse had not been discussed with or reported to the local authorities safeguarding team in accordance with local and national guidance. For example we saw that one person had become physically challenging and put another person at risk of physical harm. Additionally a relative alerted us to an incident when their relation had been given a larger amount of supplementary nutrition prescribed for another person. This was an error which had put the person at risk but the provider had not reported this to us or the safeguarding team. We asked the registered manager to report these concerns retrospectively to ensure the safeguarding authority were aware of these risks to people living in the home.

Some people's movements were being restricted by staff. We saw one person wanted to leave the building. On one occasion staff stood in front of them to stop them which caused them distress. Staff told us that another person also regularly attempted to leave the building, particularly at night time. A member of staff told us they no longer allowed this person to go into the garden as on one occasion it had taken five members of staff to persuade them to go back into the home. We saw there were no legal permissions in place to allow these people to be restricted in this way. Staff we spoke with did not understand that by restricting people's movement without permission they were not acting lawfully which could have an impact on the rights of people who used the service.

The above evidence shows that people were not consistently protected from the risk of abuse or restrictions on their liberty. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that there were assessments of risk associated with people's care. The assessments provided staff with information about the levels of support people needed to be moved safely or to ensure they received adequate nutrition delivered in a safe manner. We saw that the assessment to support one person's mobility was not accurate despite a recent review. For example, we read in the person's care plan that they required support from one member of staff to move and to vacate the building in an emergency, guidance from staff would be required. We saw that this person needed to be moved with equipment operated by two members of staff as they were unable to move independently. A member of staff told us that the level of support the person required could change on a day-by-day basis however this was not reflected in their care plan. We saw in the care plan for another person that they had a medium risk of choking whilst eating and drinking. Staff had received guidance from a speech and language therapist who had advised that they must have

'full supervision and receive continuous verbal and tactile prompts' whilst eating their meal to ensure they slowed their eating down. We saw that this person was not provided with continuous support or supervision during their meal. This meant they did not receive the support that was planned to keep them safe.

Information regarding recent accidents was not readily available. We asked the registered manager to provide us with a record of the accidents which had occurred so far in the month so that we could check that appropriate action had been taken. The registered manager told us there had been no accidents however we identified by speaking with relatives and checking people's daily care records that four people had fallen during that month. One person had required the attendance of paramedics to attend to their injury. This demonstrated that communication about people's risks was not always effective.

We saw that people's medicines plans were not always followed to ensure they received their prescribed medicine at the correct time. We saw it was recorded that one person was given medicine used to calm them before the prescribed time. A member of staff told us, "[Name of person] refuses to take this medicine at teatime so we give it at lunchtime". We saw that the person was calm and did not require this medicine at that time to reduce their anxiety. The member of staff was unable to tell us why the person needed the medicine. There was no guidance in place to explain when the person might need the medicine or the maximum amount that could be given safely. The registered manager told us that the person's doctor had agreed that this medicine could be given earlier than prescribed however they were unable to provide us with evidence of this. We saw that a member of staff was still administering people's breakfast medicines at 11.45 am. The member of staff told us, "The medicine round takes a long time due to staff asking for help, visitors and the GP calls". We saw during the morning that this member of staff was frequently interrupted by staff asking for support to provide personal care. We saw that the member of staff had not been provided with a tabard reminding staff and visitors that they were administering medicines and should not be disturbed. This meant that there were no protective measures in place to support the safe administration of medicines.

The above evidence demonstrates that effective systems were not in place to ensure people consistently received their care in a safe manner. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a process in place to ensure new staff were suitable to work within a caring environment. A member of staff confirmed that they were asked to provide information about their previous employment, provide references and complete police checks before they were able to start working in the home. We looked at four recruitment files which provided evidence that the recruitment process had been completed before new staff were able to work with people.

Requires Improvement

Is the service effective?

Our findings

At our comprehensive inspection on 24 March 2016 we judged that staff were not meeting the requirements of the Mental Capacity Act 2005 (MCA) and there was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following our last inspection we received an action plan from the provider which stated that where necessary people's mental capacity would be assessed, decisions made on their behalf would be demonstrated to be in their best interest and Deprivation of Liberty Safeguards referrals would be made for everyone who needed them by 30 September 2016.

At the focused inspection on 26 October 2016 we found that the provider had not followed their action plan in relation to the requirements of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 within the time scale they had set for themselves.

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. Some people who used the service were living with dementia. Relatives and staff told us that some people were unable to make important decisions for themselves or without support from others. We read in one person's care plan that their relatives had made decisions on their behalf about the personal care they received. Another person's relatives had been asked to make a choice about resuscitation should they collapse. Relatives told us they had been consulted because their relations did not have capacity to make choices about their health, safety and welfare however there were no capacity assessments recorded to support this or to confirm that all decisions made for people were judged to be in their best interests.

We saw that some people had sensor mats in their rooms to alert staff when they were moving around. These had been installed to reduce the risk of falls. We did not see that people had been consulted about this potential deprivation to their free movement or that their capacity to agree had been considered. 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 saw that four people who used the service had been assessed and had current (DoLS) restrictions in place which had been considered by the assessor to be in their best interest. The registered manager had failed to inform us, as is legally required, that people who used the service were being legally deprived of their liberty. We saw that the DoLS authorisations in place for two people had expired and a re-application had not been applied for. We saw and the manager confirmed there were no risk assessments in place to ensure that these people were supported in the least restrictive manner to maintain their safety.

The registered manager told us that a further 16 Deprivation of Liberty (DoLS) applications had been made to the local authority and people were waiting for an assessment. We saw there was a chart which included people's names and a pencilled date which we were told indicated the date the application had been made. However, there were no capacity assessments in people's care plans to support the DoLS applications for

these people and we saw there were no copies of the applications to the authorising authority. We saw and the registered manager confirmed there were no interim risk assessments in place to ensure people's care was provided in the least restrictive way possible whilst they were waiting for formal assessment and permissions.

Staff could not describe the requirements of the Act and were not aware of restrictions being placed on people. One member of staff told us, "I don't know what DoLS is". Another member of staff said, "I don't know if anyone has a DoLS. I haven't had time to go through the care plans". This meant staff we spoke with did not understand their responsibilities associated with the Act.

This is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People were provided with a varied diet and a choice of food and drinks. People told us they enjoyed the food, were able to choose what they ate and were provided with choices. One person told us, "The food is good, lovely", and a relative told us, "The food must be good because my relation has put on loads of weight since they've been here". Another relative said, "[Name of person] is having fortified drinks, I'm so pleased they're looking after them". We saw that frequent drinks were offered throughout the day and there cold drinks available in each of the communal living rooms.

There were arrangements in place to provide staff with the skills and knowledge they required to care for people effectively. A member of staff told, "We do all our training online except moving and handling which is a practical session". Staff we spoke with had mixed views about the opportunities they had to discuss their performance and development and spoke of inconsistency with the way supervision was provided. Some members of staff told us they had not had regular or recent one-to-one supervision sessions. One member of staff told us, "I haven't had supervision for ages. Just given a form to sign". Another member of staff said, "One of the seniors does our supervision but I haven't had one since last year". However another member of staff told us they had been provided with their supervision more recently and said they would raise concerns immediately with the unit manager if they were worried or needed support.

People were visited by other healthcare professionals whenever additional advice or involvement was required to support their physical, mental and psychological health. One relative told us, "The doctor comes in or they are taken to the surgery". We saw that healthcare professionals came into the home and staff kept records of their visits.

Requires Improvement

Is the service well-led?

Our findings

At our comprehensive inspection on the 26 March 2016 some relatives told us they were frustrated by the lack of action that was taken in response to their concerns about the staffing levels in the home. The relatives we spoke with at our focused inspection on 26 October 2016 repeated their concerns and described their frustration that their worries were not being addressed. One relative told us, "Nobody listens to us. New staff come and they're great but they don't stay because of the workload they're expected to do. There are meetings for relatives but when you don't feel anyone bothers to listen to you there's no point in going. They have an answer for everything but don't do anything". Another relative said, "The staff are fantastic and look after people really well but I don't think they're very happy working here". Staff opinion about their support had changed since our last inspection. Staff told us they shared the views and frustrations of relatives about the staffing levels and responses to the frustration. One member of staff told us, "There's no point in going to the meetings. We voice our opinions and say we can't get people up in the time we have but we don't think it gets written down most of the time. We work hard". Another member of staff said, "There is a lot of moaning about staffing levels at the staff meetings". This demonstrated staff did not feel they were listened to about their concerns.

At our comprehensive inspection we advised the registered manager that people's records needed to be kept securely to protect their confidential information. We saw that no improvements had been made to prevent people's personal information being accessible to others. We saw people's records were kept in an unsecured cupboard in an office with the door fully open. People's medicine administration records and information about their personal care were left in public areas of the home which meant that people's information could be seen or damaged by others.

There was an audit programme in place to monitor the quality of the service. We had identified errors on some people's medication administration records and saw these had been highlighted on a previous audit but there was no record of action taken. Staff told us they sent the information on the audits to the registered manager but had not received any feedback. The registered manager told us that action on the audits was the responsibility of the unit managers. Relatives told us that they were concerned at times about the cleanliness of the home, particularly the dining rooms. Following breakfast we saw that the tables were not cleaned until lunchtime. We spoke with the housekeeping staff and members of the care staff who were unclear about their individual responsibilities in cleaning the dining areas. The registered manager confirmed that there was some confusion about the cleaning responsibilities. This meant there was a lack of effective communication in the home in relation to this matter.

The above evidence shows that the provider was not responding to people's views and keeping their records secure. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
To comply with their registration requirements the registered manager must send us notifications about important events which happen in or affect the running of the home. During the inspections we identified that the registered manager had not always complied with this statutory requirement to keep us fully informed.

People told us they were provided with opportunities to discuss plans for their entertainment and asked for their opinion about the food. We read the minutes of the last residents meeting and saw that people had been asked to comment on naming the two separate units within the home rather than referring to them as 'upstairs and 'downstairs'. People were also encouraged to make suggestions about activities they might like to be provided for them. This meant that people had been involved in decisions about the home they lived in.

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 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	11(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	12(1) (2) (a) (b) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	17(1) (2) (a) (c) (e)