Purelake (Chase) Limited

The Chase

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Chase is a residential care home providing personal care to up to 31 people. The service provides support to older people and people living with dementia. At the time of our inspection there were 20 people using the service.

People's experience of using this service and what we found
The quality of the service had improved since our last inspection, but further improvements were required to ensure people always received a good service.

People's medicines were not always managed safely. Medicines management processes had improved however, effective systems were not in place to manage all medicines which were no longer needed. Some medicines records were not complete. The provider had introduced new checks and audits since our last inspection. Medicines audits had not identified the shortfalls we found. Other audits had been effective, and action had been taken to continually improve the service.

People told us they felt safe living at The Chase. Their care had been planned to mitigate risks to them and maintain their independence. People were protected from the risk of the spread of infection. Effective systems were in operation to support people to see their visitors safely. Any safeguarding risks had been identified and shared with the local authority safeguarding team. New staff had been recruited safely. Any accidents or incidents had been analysed and action had been taken to reduce the risk of them happening again. When things had gone wrong the provider had apologised.

The culture at the service had significantly improved and everyone we spoke with told us the registered manager was approachable and listened to them. People, relatives and staff had been asked for their views and these had been used to improve the service. Systems were in operation to make sure staff were always up to date and knew about people's needs. The registered manager and staff worked closely with health and social care professionals to make sure people received the care they needed in a timely way.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update.
The last rating for this service was inadequate (published 10 December 2021). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made and the provider was no longer in breach of some regulations. However, they remained in breach of two regulations.

This service has been in Special Measures since 31 August 2021. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
We carried out an unannounced focused inspection of this service on 27 July 2021. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, safeguarding service users from abuse and improper treatment, good governance and fit and proper persons employed.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from Inadequate to Requires Improvement. This is based on the findings at this inspection.

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

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to medicines management and checks and audits at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

The Chase

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was completed by one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all this information to plan our inspection. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with four people and six relatives about their experiences of the service. We spoke with six staff including the registered manager, deputy manager, and four care staff. We reviewed a range of records. This included four people's care records, multiple medication records and two staff files in relation to recruitment. A variety of records relating to the management of the service, including checks and audits were reviewed.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely
At our last inspection the provider had failed to operate effective systems to ensure medicines were stored and administered safely. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12. Records in relation to medicines were not consistently completed.

● Records relating to medicines had improved since our last inspection, however, further improvements were required. The name and strength of some medicines no longer required was not recorded along with the quantity and person they were prescribed to. This was not in line with national guidelines. The stock levels of these medicines could not be checked to ensure they were accurate and that medicines had not been misappropriated.
● Since our last inspection action had been taken to ensure medicines were not stored above the manufacturer's recommended maximum temperature. However, complete records of the temperature of the medicines room and fridge had not been maintained. The registered manager could not be assured the action they had taken was always effective.

The registered provider had failed to ensure records relating to medicines were always complete. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other records were fully completed including the application of prescribed creams to keep people's skin healthy. Complete records were now kept about medicines received into the service and administered.
● Guidance had been provided to staff about how to administer people's 'when required' medicines. However, this did not include how staff would know when the person required the medicine. Staff explained to us how they knew people needed when required medicines, such as a change in their facial expression or body language. Following the inspection, the registered manager put this guidance in place for staff.

Systems and processes to safeguard people from the risk of abuse
At our last inspection the provider had failed to consistently protect people from abuse. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of

regulation 13. People were now safe living at The Chase.

● People told us they felt safe living at The Chase. They were confident to raise any concerns they had with staff and the registered manager. They told us staff had always listened to their concerns and acted on them.
● Incidents between people were rare. When they had occurred, the registered manager had reported them to the local authority safeguarding team. They had considered action to keep people safe, such as how to support people to remain calm.
● At our last inspection guidance had been provided to staff about tying a person to the chair to reduce the risk of them falling. The provider had removed this guidance and completed an investigation. The person had been referred to an occupational therapist for advice and guidance around how to remain safe.
● Staff had completed safeguarding training and were confident to raise any concerns they had. They told us the registered manager acted "straight away" on any concerns they raised. The registered manager had reported any concerns they received to the local authority safeguarding team for consideration. The registered manager had acted to keep people safe while investigations were completed.

Assessing risk, safety monitoring and management: Learning lessons when things go wrong
At our last inspection the provider had failed to accurately assess and mitigate risks to service users. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12 in relation to risk management. Risks to people had been assessed and reviewed and action had been taken to mitigate risks.

● The provider completed an analysis of accidents and incidents each month to look for patterns and trends. Action was taken to reduce the risk of accidents happening again. For example, people who had fallen were referred to the falls clinic for support and advice. While people were waiting to see health care professionals additional support was provided, such as a second staff member or additional equipment.
● The risks of people falling out of bed had been assessed. When a person had fallen or was at risk of falling bedrails had been fitted to keep them safe, with people's agreement. When bedrails increased the risk of injury other actions had been taken to protect people, such as a low bed and crash mat. These measures had been effective.
● Since our last inspection people with diabetes had been reviewed by their GP. The monitoring of blood glucose levels had been discussed and staff were following the GPs advice. Staff had completed training around diabetes and knew the signs someone's blood glucose levels were becoming too high or too low and the action to take. Individualised guidance was available for staff to refer to.
● The risk of people developing pressure ulcers had been assessed and action had been taken to reduce the risks. People used different types of pressure relieving equipment including air mattresses and cushions. These were set correctly and monitored through the day to make sure they were operating correctly. People were encouraged to change their position regularly and take short walks to further reduce the risk. No one at the service had a pressure ulcer.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Preventing and controlling infection
At our last inspection the provider had failed to fully control risks of the spread on infection. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12 in relation to controlling the risks of infection. People were protected from the risks of the spread of infection.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The provider's visiting policy followed current government guidance. People received visitors when they wanted in their bedroom or communal areas. Visitors were required to show evidence of a negative Covid-19 test. Visits were booked in advance to allow for COVID-19 test results to be received and logged. Relative's comments included, "They've followed the COVID-19 rules well, I've been able to book visiting slots easily" and "We got emails about changes to visiting rules. We do a test at home and bring proof of being negative. We need to book a visiting slot but have always been able to get times that suit us. We also take our relative out whenever we like'.

Staffing and recruitment
At our last inspection the provider had failed to complete all the required checks on new staff. This was a breach of regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19. People were protected by robust staff recruitment processes.

● The provider had completed robust checks to ensure staff were of good character and had the skills required to fulfil their role before they began working at The Chase. Any gaps in staff's employment history had been identified and explained. Staff members right to work in the UK had been verified. Other checks included Disclosure and Barring Service (DBS) checks and obtaining references. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The

information helps employers make safer recruitment decisions.

● People and relatives told us there were always enough staff on duty to offer them the care they needed. Our observations during the inspection confirmed this. A relative told us, "There seems to be sufficient staff, I don't see any signs of them being rushed or not having time for the residents".

● Staff said they now had time to spend with people and were encouraged to build relationships with them. They told us, "We have time to chat to people and have a laugh with them". We observed staff and people were relaxed in each other's company and shared jokes.

● The registered manager completed a monthly dependency assessment to identify people's needs and determine how many staff were required at different times of the day. Care staff were free to support people because other staff including house keepers and a chef completed other tasks.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Inadequate. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Continuous learning and improving care
At our last inspection the provider had failed to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17. Checks and audits completed had not identified the shortfalls we found in relation to medicines.

● The quality of the service had improved since our last inspection, but further improvements were needed. Checks on medicines did not include reviewing the processes used to return unwanted medicines. The shortfalls in the process we found had not been identified. The provider had identified the temperature of the medicines room and fridge were not being taken consistently. Actions they had taken to improve this had not been effective and gaps in the records continued.

The provider had failed to assess, monitor and improve the quality and safety of the service. This left people at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other checks and audits had been effective. For example, care plan audits had identified where amendments were needed and changes had been made to the care plans.
● Relatives told us the service had improved since the provider had become the registered manager. Their comments included, "Things are much improved since the new manager started. Staff attitude is better and there are no smells, everywhere is much cleaner" and "The new manager has done amazingly. They are always around when I visit, or I can ring them or their assistant".

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
At our last inspection the provider had failed to operate effective systems to seek and act on feedback from service users, their relatives and staff. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of

regulation 17 in relation to operating effective systems to seek and act on feedback. People, their relatives and staff were asked for their views and these were used to improve the service.

● The provider had analysed people's responses to quality assurance questionnaires and provided them with feedback. This included what action they would take to improve the service as people suggested. The majority of the feedback had been positive. People's comments had included, 'Everyday there's something different to do' and '(The staff are) totally lovely. All have a sense of humour. All staff are very, very nice. I think of them as my friends'. People were also asked for their views at regular meetings. Again, these had been positive.
● Relatives had also been asked for their feedback which was also very positive. Everyone said they had been involved with planning their relatives care and they had a good relationship with the registered manager. One relative had commented that they would like their loved one to be able to take part in gardening as this was a pastime they enjoyed. Plans had been put in place in response to this comment to build raised beds so everyone could be involved in gardening if they wished. A relative told us, "I haven't had any problems, but I would be happy to talk to the manager about them".
● Staff told us felt much more involved and were now confident to make suggestions to improve the service. They said the registered manager listened to their views and was happy to try new things. One staff member told us, "Everyone has their say". This was an improvement on our last inspection when staff had not felt listened to or involved.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● Since our last inspection the provider had been registered as the manager of the service. They were supported by a deputy manager and worked well as a team. Staff told us managers were "approachable" and "interested". Relatives told us the registered manager was "approachable" and "nice to talk to". The registered manager had displayed the current CQC rating at the service and had notified us of any significant incidents which had occurred.
● Following our last inspection, we applied a condition to the provider's registration requiring them to tell us each month what they had done to address any shortfalls highlighted by their checks and audits. They had complied with the condition and sent us detailed reports demonstrating what action had been taken to address any shortfalls found. We found the action taken had been effective and the service had improved.
● The registered manager had introduced a robust handover system to ensure staff always had the information they needed to provide consistent care. This included discussing anything significant, such as health care professionals' recommendations. Copies of any new care plans were included in the handover and staff were required to sign them to confirm they had read them. One staff member told us, "I know exactly what is going on".
● Staff were motivated and felt appreciated. One staff member told us they were now proud to work at The Chase. Staff worked well as a team. The registered manager had rearranged the way staff were deployed and staff stepped in to help their colleagues if needed. Staff were encouraged to challenge each others practice rather than relying on the registered manager to address minor issues. One staff member told us, "The registered manager has explained to us we can be friends and challenge each others work"
● Staff were reminded of their roles at regular staff meetings and supervisions. The registered manager checked staff understood parts of their role and reminded them if necessary. Staff were encouraged to share what helped them fulfil their role and good practice.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager had developed an open culture, where staff felt relaxed and empowered to fulfil their roles. All the staff we spoke with told us they looked forward to going to work and they were no longer "walking on eggshells".
● The provider's philosophy of care was to support people to 'maintain their daily living skills'. The registered manager knew when people's care needs fluctuated and had designed their care to ensure they were supported to remain independent. Staff encouraged people to continue to do things for themselves.
● When things had gone wrong the provider had apologised to the person and their relatives. They had explained the outcomes of any investigations and actions taken to prevent a similar occurrence happening again.
● Since the last inspection the provider had been open and honest with us about any shortfalls at the service. They had reflected on what had gone wrong and taken action to change practice, so it did not happen again. A relative told us, "They were upfront about the home being in 'special measures'".
● The registered manager had developed a culture where staff felt comfortable to say when they had made a mistake. Staff told us there was no longer a blame culture and registered manager used mistakes as an opportunity for development. They explained to staff where things had gone wrong and what needed to be done to put things right.

Working in partnership with others
● Since our last inspection the provider had worked closely with health and social care professionals to drive improvements at the service. They told us, "We don't ever turn down any help".
● Staff had worked with the local GP surgery to improve the care people received. They had taken up offers of training and a number of staff had completed RESTORE2 training. RESTORE2 is a nationally recognised tool used to identify and escalate any physical deterioration in a person's health. A health care professional told us staff identify any deterioration quickly and gave them the information they needed to make a clinical decision.
● Previously health care professionals told us staff had not always been supported to follow the advice and guidance they had given. At this inspection they told us this had changed, and staff now followed their advice and guidance. This had been shared at the handover and comprehensive records were maintained for staff to refer to.
● Visiting social workers told us people's care plans and other records contained all the information they needed to review people's needs. They told us the registered manager and deputy manager knew people well and freed up their time to support reviews.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to ensure records relating to medicines were always complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the quality and safety of the service.