Care Quality Commission

Chasewood Care Limited

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Inspection report

Chasewood Lodge
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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Requires improvement
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

The inspection took place on 3 and 4 November 2015. The visit was unannounced on 3 November 2015 and we informed the provider we would return on 4 November 2015.

Chasewood Lodge Residential Home provides accommodation, personal care and support for up to 107 older people living with dementia and physical frailty due to older age. At the time of the inspection 79 people lived at the home.

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 in post.

Summary of findings

At our previous inspection in November 2014 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 and safe recruitment of staff. We also found breaches in notifying us about incidents and deaths of people who lived in the home. As a result we asked the provider to send us a report to tell us what action they had taken to become compliant with the regulations.

At our previous inspection in November 2014 we found improvement was needed for people that had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) records in place. We made a recommendation for the provider to seek guidance about the completion of DNACPR records to ensure they were acting within the legislation.

During this inspection we found some progress had been made to address some of the issues where action to improve was required, but sufficient improvements had not been made.

We found people had their prescribed medicines available to them, however, we saw some errors that had not been identified by staff. For example, some medicines had been signed for as given but were still in the packaging and had not been administered. We also found some issues with the safe management of medicines. For example, records of controlled drugs did not reflect the stock we found. Actions to reduce the risk of harm to people were not always identified. Staff did not have the knowledge they needed to deal with emergencies that might arise, such as a person choking or in the event of a suspected fire.

Staff had a limited knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. This meant some staff were not aware of their responsibilities under this Act. Staff did not always give people choices about food and drink.

We saw nutritious meals were available to people. However, choices were not always offered and people were not always offered the support they needed to eat their meal. Although staff told us they felt there were enough staff allocated to each shift, some felt non-care tasks, such as washing up crockery after meals, took them away from supporting or spending time with people. We saw no additional staff were allocated in light of the additional duties undertaken by care staff.

People's care records were sometimes not sufficiently detailed to support staff in delivering care in accordance with people's needs and wishes, and staff were not always able to tell us about people's needs. There were limited social activities offered which did not always meet people's needs. People's personal information was kept securely so only those authorised could access it.

Some systems were in place to assess the quality of the service provided but these were not effective. People and relatives were not asked for their feedback on their experiences of using the service. We found there was insufficient management oversight to check delegated duties had been carried out effectively.

We found a number of breaches of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for this service is 'Inadequate' and the service is therefore in '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.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

Summary of findings

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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

People had their prescribed medicines available to them but a safe management of medicines was not always followed by staff. Although risks associated with people's care were assessed actions were not always put into place to reduce the risk of harm. Staff did not always have the knowledge to know how to deal with emergencies. People were protected against the risk of abuse because staff were safely recruited and the provider had completed the required pre-employment checks to ensure they were of good character.

Requires improvement 

Is the service effective?
The service was not consistently effective.

Staff had undertaken training to deliver care and support but their competencies to undertake their job roles were not always effectively assessed. Staff had a limited knowledge of the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, so did not always work within the law. People were not consistently offered choices or given the support they needed to eat and drink. People were supported to maintain their health and were referred to health professionals when needed.

Inadequate 

Is the service caring?
The service was not consistently caring.

People and their relatives told us that staff were kind and caring towards them or their family member, however, we observed that people's care needs were not always met. People were not routinely supported to express their views or be involved in decisions about their care.

Requires improvement 

Is the service responsive?
The service was not consistently responsive.

People did not always receive care that was personalised to them. People's care plans were not always detailed to support staff in delivering care in accordance with people's needs and preferences. There were limited opportunities for people to pursue their hobbies, interests or engage in social interaction.

Requires improvement 

Is the service well-led?
The service was not consistently well led.

Inadequate 

Summary of findings

The provider had some systems in place to monitor the quality of the service provided but had not ensured these were effective. This meant that a number of shortfalls in relation to the service people received had not been identified. Therefore actions had not been taken to drive improvement. Staff told us they felt supported by the registered manager.

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 3 and 4 November 2015. The visit was unannounced on 3 November 2015 and we told the provider we would return on 4 November 2015. The inspection team consisted of two inspectors and a pharmacist inspector on day one and two inspectors and an expert by experience on day two. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of care service.

We reviewed the information we held about the service. This included information shared with us by the local authority and notifications received from the provider about, for example, safeguarding alerts. A notification is information about important events which the provider is required to send us by law.

Most of the people living at the home were not able to tell us about how they were cared for due to their complex needs. However, we used the short observational framework tool (SOFI) to help us assess if people's needs were appropriately met and if they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experience of people who, due to their dementia, could not talk with us.

We spoke with five people and spent time with other people on all the units within the home. We spoke with six relatives who told us about their experiences of using the service. We spoke with staff on duty including 16 care staff, one cook, one laundry assistant, two deputy managers, the registered manager and the director. We spent time with and observed care staff offering care and support in communal areas of the home.

We reviewed a range of records, these included care records for 12 people, 16 people's medicine administration records and five people's Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) records. We reviewed five staff induction, training, support and employment records, quality assurance audits and minutes of staff team meetings.

Requires improvement

Is the service safe?

Our findings

When we inspected the home on 12 November 2014 we found people's medicines were not stored, handled or managed safely by staff. Legal requirements for medicines that required extra checks and special storage arrangements (controlled drugs) were not followed. Records for the receipt of medicines, stock checks, disposal and administration of medicines were not accurate and staff were unable to explain why. We could not therefore be assured people were always given their prescribed medicine. We found no information was available to staff to determine when people should be given medicines prescribed to them 'when required.'

At this inspection we checked to see if appropriate arrangements were in place for obtaining people's medicines. Staff told us how medicines were obtained and we saw that supplies were available to enable people to have their medicines when they needed them. There were systems in place for stock checking medication, and for keeping records of medication which had been destroyed or returned to the pharmacy. These records were accurately kept and had improved since our last inspection. However, we found some practices had not improved and identified other areas where improvement was required.

Medicines were not always stored safely and securely. Two fridges were used to store medicines. However, there were no temperature records available for one of the fridges to demonstrate it was checked that medicines were stored within the required temperature range of 2-8 degrees. One staff member told us, "The records have been wrongly removed with other paperwork". Staff were unable to locate the records during our inspection. In addition, we found one medicine was stored in an unlocked third fridge located in the upstairs communal lounge area kitchenette. This fridge was for the storage of food products and was not being monitored for temperature. If medicines are not stored at the correct temperature, there is a risk they may not remain effective.

Controlled drugs were stored safely following guidance and recorded in the register. The controlled drugs register was not being checked by staff on medication audits and the register was not accurate in regard to the contents of the controlled drug stock. We found three ampoules (containers) of a controlled medicine were in the cupboard but the register recorded five should be there. Staff told us they did not know they had to log the removal of controlled drugs from the cupboard in the register. One staff member told us, "We give the medicine ampoule to community or district nurses that visit people in the home. They administer it." We saw this was not in line with the provider's medicine's policy. There was an increased risk of controlled drugs being misused which had not been identified by the provider.

We looked at the medicine administration records (MAR) for 16 people on five units of the home. People we spoke with told us they were given their medicines on time. One person told us they had "no problems" with how their medicines were given. Another person said, "I always get given my medicines." We saw arrangements were in place for recording the administration of medicines. Most medicine records we looked at showed people were getting their medicines when they needed them. MAR charts showed that medicines administered were signed for and where not administered this was clearly identified. However, we found one person's medicines had been recorded by staff as given but we saw the medicines were still in the monitored dose system packs. This error had not been identified by the registered manager and showed us people did not always receive their medicine as prescribed.

Some people had medicine prescribed to be given 'when required.' For example, an inhaler for breathlessness or paracetamol for pain relief. Staff told us one person found it easier to express their needs in their first language. We saw one staff member spoke their first language with them to ask them if they needed any 'when required' pain relief and their medicine was given to them. We found people's MARs recorded times and dosages of 'when required' medicines were given to people. However, there was no guidance to staff about when 'when required' medicines' should be offered or given to people. This meant no improvement had been made since our last inspection.

Covert administration of medicines is where medicine is given without the person's knowledge, for example mixed with their food. At this inspection we found one person was receiving their medicines covertly. There had not been a meeting to decide whether receiving medication covertly was in this person's best interests and no guidance about how the medicines should be administered. One staff member told us, "The GP has approved their medicines to be given covertly." We discussed this with the staff member

Is the service safe?

who had administered the medicines. They told us, "It's okay to crush them." Staff confirmed to us no guidance had been sought from a pharmacist to ensure that it was safe for the medicines to be crushed. Crushing medicines may, for example, result in reduced absorption of the medicine. The registered manager told us a staff member had completed a mental capacity assessment. This was not in line with the requirements of the Mental Capacity Act 2005, which required a referral to have been made to the local authority for them to arrange for a healthcare professional to undertake a mental capacity assessment.

We looked at the arrangements in place for homely remedies. Homely remedies are medicines which people can take without a prescription. In three of the home's clinic rooms, we saw liquid, soluble and solid tablet paracetamol that staff told us were being used as homely remedies. We found there was no information available to staff about which homely remedies people could take, or for what conditions. There was no information about the judgement used to decide whether the homely medicine was suitable for a person and no record on people's MARs to record when a homely remedy was given. One staff member told us, "I'd check the care plan before giving paracetamol to anyone." Of the 12 people's care records looked at, none had any information about the use of homely remedies. We discussed our concern with the registered manager. They told us, "I'll arrange for the removal of all homely remedies from the home."

We saw staff members completed audits to check the safe management and administration of medicines. Records of audits showed no concerns had been identified by staff. We found people were not always protected against the risks associated with medicines because the provider did not safely manage medicines in the home.

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

When we inspected the home on 12 November 2014 we found some staff had started working at the home before all the necessary recruitment checks to ensure they were of good character had been carried out. During this inspection we found that, overall, improvement had been made. One staff member told us, "I completed my application form to work here when I attended for an interview. The manager phoned people for a reference for me during my interview. I was then offered the job. I started two days later on a probationary contract." Another staff member told us, "I gave the manager information so that checks could be completed before I worked alone with people in the home." We looked at five staff employment records. We found that initial checks from the Disclosure and Barring Service (DBS) had been completed before people started working with people that lived there. Whilst new staff were on their probationary contract, we saw that a full DBS certificate had been applied for and received by the provider. The DBS is an organisation that holds details about people's criminal records.

Of the five staff employment records looked at, we saw one did not have a completed application form and two had no record of the staff member's identify being checked. This showed us that whilst overall, improvement had been made in undertaking checks to ensure staff were of good character, further improvement could be made to ensure staff employment records were complete.

Care records showed some risks to people's health and welfare had been identified and assessed. Staff told us they kept people safe by ensuring corridor areas were 'clutter free' so that people were not at risk of tripping over. One staff member told us, "I keep people safe by making sure if we use the hoist to transfer a person from an armchair to a wheelchair, there are two staff."

Although risk assessments had been undertaken, we found they lacked detail about what actions staff should take to reduce the risk of harm or injury to people. One person had a falls risk assessment that described them at 'medium risk' of falls and recorded they may 'wander around at night.' No actions were described to tell staff how to reduce the risk of falls. We discussed this with staff and asked if measures such as a pressure sensor mat had been considered so that staff were alerted if the person got out of bed during the night. One staff member said, "That's a good idea. I don't think that has been thought about. I think we just rely on staff noticing if the person gets up or not." We observed one person, who was asleep, was gently woken up by a staff member, who informed the person it was time for lunch. We saw the staff member did not give the person sufficient time to fully wake up before they supported them to walk to the dining area. We saw the person was unsteady and was placed at risk of falling.

One communal lounge kitchenette had a low-level wooden gate that restricted access to the kitchenette. One staff member told us this was to prevent people from going into

Is the service safe?

the kitchenette when the 'cook-chill' cooker was on. We asked why some meals were cooked in the kitchenette and one staff member said, "The cooker is too big to fit in the kitchen and also it means meals are served in these units quicker than waiting for the kitchen to send them to us." We later saw one person walk into the communal lounge and heard a staff member tell them they should not be in there because the cooker was on. The staff member told us, "This lounge is closed because of the cooker." We told the staff member we had found both the lounge door and wooden gate open while the cooker was on. They said it should be closed and on leaving they closed the lounge door. However the door was not secured and presented a potential risk. We found the use of the cooker in the kitchenette restricted people's access and use of the lounge for periods of time each day.

We asked staff how they would deal with emergencies, for example a person choking on their food or the fire alarm sounding. Most staff told us they would press the 'buzzer' to summon help. One staff member told us, "I think the senior carers are the first aiders." But, another staff member said, "Everyone is a first aider here." We spoke with some staff that had completed first aid training and asked them what they would do if a person was choking. A few first aid trained staff were unable to describe the safe action they would take which meant, in the event of such an emergency, people may be placed at risk of harm.

All staff told us they had received fire safety training. However, staff spoken with gave us different responses when we asked them about the procedure they should follow in the event of a fire. One staff member told us the home's fire alarm system was connected directly to emergency services so there was no need to call the fire brigade. However, we saw the home's fire procedure stated the fire brigade should be called. The fire procedure informed staff to 'silence' the alarm. This action would place people at risk because the alarm sounding is to alert people, visitors and staff there is a risk of a fire in the building. One staff member told us, "If we thought there was a fire, then all staff should leave the building. We've been told to leave all people in the building." Another staff member told us, "Staff leave the building and take some people outside with them." A further staff member said, "I suppose we'd try to move people to a safe area, but we haven't got any equipment really so it would be hard." We asked if the home had a designated fire marshal who would co-ordinate a zoned evacuation within the home. The registered manager said, "No, we've never had a named fire marshal, but it's a good idea. I've got a notice board I could use to display such information." We found the home's fire procedure was unclear about the action staff should take and was confusing. We found none of the staff asked about fire safety arrangements had the knowledge to deal with an emergency such as a fire in the home.

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

Staff told us they had completed training to safeguard people from abuse. Although some staff were unsure as to whether they needed to record any concerns about abuse, they all told us they would speak with the senior person on shift. One staff member said, "If I thought someone was being abused I'd tell the deputy or the manager." One deputy manager told us, "I feel the manager would listen to any concerns raised to them. If I felt concerns were not responded to I would go to you at CQC."

One person told us, "I feel safe here. The staff look after me." One relative told us, "My family member has been here a long time. It's alright here. I know they are safe." Another relative said, "Yes, I feel my family member is safe here."

Staff told us they felt there were enough staff on each shift to meet people's needs. One staff member said, "We all pull together to help each other out. We've got enough staff." Another staff member told us, "Staff all pull together." However, we overheard one staff express their concern to another staff member that the afternoon shift had been 'badly planned, because it left only one staff member' on one of the units in the home. We discussed how staffing levels were determined with the registered manager and they told us, "We ensure there are two staff on each unit, though one unit has more because people's needs are higher. We would increase staffing according to the level of support people need." Although staff could not recall any examples of when this had happened, they told us they felt the registered manager would increase staffing if needed.

We looked at the premises and equipment to check they were safe and fit for purpose. We checked window restrictors in some first floor bedrooms, bathrooms and communal lounges and found they were effective in preventing windows from being opened widely, so that people were protected from falling. One fire exit door was

Requires improvement

Is the service safe?

partly blocked due to it being used as a wheelchair storage area. We discussed this with the registered manager. They said, “It is only partly blocked. People could get through if they needed to.” Whilst we agreed the fire exit was not totally blocked we found it was partially obstructed. Fire exits should be kept clear of any obstruction. We saw one person was sitting on a special cushion to protect their skin. We saw the plastic covering was torn and the foam protruding. This meant the special cushion could not be cleaned properly and was an infection control hazard. We discussed this with the registered manager and saw immediate action was taken so the person could sit on a special cushion in good condition and the damaged one was removed.

During our last inspection we had noted some areas of the home were in need of maintenance. During this inspection, we saw some issues had not been improved. For example, cupboard doors in the communal lounge and kitchenette areas which had either no seal or peeling seals. This meant areas could not be cleaned properly and was an infection control risk. We discussed these issues with the registered manager and director. The registered manager said, “There is a rolling programme of refurbishment in place. We’ve been doing a lot of work in the empty section of the building ready for when this is re-used at some point in time.” We asked if there was any time scale for the refurbishment of worn areas in parts of the building where people were currently living. The director told us, “The timescale is for all work to be completed by January 2016.” The director gave us a copy of their plan that included replacing worn kitchenettes with new fittings and redecorating worn décor.

Inadequate

Is the service effective?

Our findings

When we inspected the home on 12 November 2014 we found improvement was needed for people that had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) records in place. We made a recommendation for the provider to seek guidance about the completion of DNACPR records to ensure they were acting within the legislation. At this inspection we asked which people had a DNACPR in place. Neither the deputy nor registered manager could verbally list people with a DNACPR, the registered manager said, "DNACPR information is in people's care records." We discussed our concern that this may delay the correct course of action being taken for individuals in an emergency situation if staff had to locate and check the person's care records. The registered manager agreed this may cause a delay and said they would ensure a list was made available so staff were aware of people having a DNACPR and updated at shift handovers.

We asked senior carers and deputy managers about what having a DNACPR meant for people and when these would be followed. Some staff were unsure of the situation when the DNACPR decision would be followed. We saw one person had a DNACPR form in their care record but saw "Needs to be resuscitated" had also been written on the form and signed by a family member. No other information was on the form. We discussed this with one staff member and they told us, "I'm not really sure if [Person's Name]'s DNACPR form would be followed or not because it has 'needs to be resuscitated' on it." Although forms seen recorded 'spoke with next of kin' we found there was no record of the discussion or whether people had been involved in the decision to have a DNACPR in place. We asked the registered manager if they had followed our recommendation to seek guidance about the completion of DNACPR forms. They told us, "I've looked on the internet for information. I've also had a conversation with the head of practice at the GP surgery we use for people. I've made every effort to seek guidance, but don't feel it has always been effective from our perspective." We found that although guidance had been sought following our recommendation, this had not been effective as we found the same concerns as on our previous inspection. This included no evidence of DNACPRs being reviewed and no evidence of a 'best interests' meeting having taken place where people were unable to contribute to decision making about a DNACPR. We found staff did not always have the information they needed to ensure people effectively received the care they needed because they did not know in which situations a person's DNACPR applied.

During our inspection, the registered manager gave us a copy of the list they had created for staff to refer to for people with a DNACPR in place. We found one person on the registered manager's list had no record of a DNACPR in their care record. Another person that had a DNACPR in their care record was not on the registered manager's list. This meant the information was not accurate and may result in the wrong course of action being taken. Following our inspection, we made the registered manager aware of this so that immediate action could be taken.

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 did the training about a year ago, but I can't recall what it's about." Although staff said they would not force people to do things and tried to give people choices whenever possible, we found staff had a limited knowledge of the principles of the MCA and DoLS and were unclear about their responsibilities.

We found 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. One staff member said, "We can't let people out. It would be unsafe for them." Staff told us there was only one person 'allowed' out of the building but they had to 'stay in the car park area and were not allowed down the driveway. One staff member told us, "The manager told us the person

cannot go any further because of the busy road." We asked staff which people had a DoLS in place. One staff member said, "I've never heard of DoLS. I wouldn't let anyone out, it's unsafe for them."

We saw that Closed Circuit Television (CCTV) was used throughout all communal areas of the home. We saw there was no notice to inform people living there or visitors to the home that CCTV was in use or for what reason and discussed this with the registered manager and director. The director told us, "We have thirty cameras in the building. The images are relayed to the main office of the home and used for people's safety." The registered manager added, "We used to have a sign but it must have fell down or got lost." We reminded the registered manager and director of their responsibilities under the Data Protection Act to inform people of the use of CCTV and they told us, "We'll ensure a sign is purchased and in place tomorrow." On the second day of our inspection we saw action had been taken and a sign was displayed. However, this was only visible to visitors entering the home. We found no signage to say CCTV was in use within the home. We asked how people living at the home were informed about the use of CCTV. The registered manager told us that the use of CCTV was mentioned in the service user guide. We found no details of how people were consulted about this or their consent to being recorded on CCTV in their care records. All staff told us they were aware of the use of CCTV in the home and felt positive about its use. One staff member said, "I feel the CCTV not only protects people that live here but also staff working here. The manager would be able to check if anything happened. " We found the registered manager and provider had not recorded people's consent to be filmed or reviewed any consent given when people moved into the home.

Staff told us five people were always cared for in bed on a permanent basis. We asked staff why this was and had different responses from staff. These included, "It's because they have no mobility," and, "It's because it is better for them. Their skin is very fragile. The community nurse team told us who should stay in bed." Another said, "It's because they are 'end of life' care." We saw a few people staff described as receiving 'end of life' care had been confined and cared for in bed for over a year. There was not a care plan for these people to identify what their needs were to be to be cared for in bed. There had been no referral made for a mental capacity assessment, 'best interests' meeting or Deprivation of Liberty Safeguard. We discussed this with the registered manager and they said, "It was the clinical decision of the community and district nurse team and staff followed their instruction." Following our inspection, we spoke with the practice nurse manager who told us their nursing team would not be involved in such decisions about people. We then spoke with the district nurse team manager and they told us their nurse team had given guidance to staff at the home for four people who they believed may be more comfortable cared for in bed. We found that while staff had followed guidance given from health professionals, they had not acted in accordance with legislation to arrange a 'best interests' meeting.

The registered manager told us that four people had a DoLS in place and two people had applications pending. We discussed other people's liberty being deprived with the registered manager. They said, "I think everyone living here should probably have a DoLS. I think it is something we need to work on and submit more referrals." We asked if the registered manager thought everyone lacked mental capacity and they told us, "I think everyone living here lacks mental capacity. There is one person that the local authority found has mental capacity, following an assessment, but I think that fluctuates a lot." We asked if referrals had been made for people to have mental capacity assessments and the registered manager told us they had not done this but staff members completed their own if needed. This was not in line with the requirements of the MCA 2005.

This was in breach of Regulation 11 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had an induction which included training and working with an experienced staff member. One staff member told us, "I'd never done this sort of work before. I did some online training, some face to face training and two shifts shadowing staff before working with people alone." Most staff told us they felt they had the skills they needed for their job role although a few identified some further training they felt they would benefit from, including caring for people living with dementia.

We heard one staff member, who had told us they had not completed their dementia care training, include various different pieces of information in a long sentence to one person with dementia. We saw the person was confused and unable to process all of the information. The provider's information to people states staff are 'highly trained and

experienced in providing high standards of care' and that the home offers 'specialist dementia care service.' We found some staff did not have the knowledge and skills they needed to effectively meet people's dementia care needs.

One person told us, "The food is quite good here." One relative told us, "My family member enjoys their food and eats well, I think the portions are large enough and food is presented nicely." One staff member told us, "The manager has a contract with a catering company that deliver prepared frozen meals. I know which people have special diets. We've always got enough stock." They showed us a range of frozen meals that catered for people's preferences. These included Caribbean, Indian and vegetarian foods as well as special diets for health conditions including diabetic and gluten free. This showed us people's needs and preferences, based on their culture or religion, could be met due to the varied range of meals available.

Although we saw the day's menu was written on a notice board in one corridor, none of the people we spoke with were able to tell us what choice there was for lunch. One person told us, "When staff bring meals here, I can make a choice." One staff member said, "We just ask people or show them what the choice is at the mealtime." However, we observed this did not always happen and people had different dining experiences. In one dining area, we heard people ask staff what was for lunch but staff said they did not know. One staff member told people they would go to find out. However, when the staff member returned they did not tell people what was for lunch. We did not always observe people were given a choice at the point of the meal being served.

We observed the support and dining experiences for people in five dining areas of the home. We saw staff in some dining areas were well organised, asking people where they would like to sit and offering them a choice of hot and cold drinks. Staff gave people time to make their choice. When people's meals were given to them, staff offered positive encouragement to people. We heard one staff ask, "Are you managing okay? Would it be helpful if I sat with you?" When one person left the dining room, they were encouraged by staff to return to their meal. Staff were heard to ask people if they enjoyed their meal. We found people's dining experience was relaxed and unrushed in this dining area. However, this was not consistent in other dining areas.

In another dining area, some people were offered and given a drink, though no choice was given. Two other people in the same dining area were not offered a drink throughout their meal. People who ate their meals in their bedrooms did not have drinks accessible to them. We saw hot plated deserts were left standing, whilst staff washed up crockery in the kitchenettes. One staff member told us, "We have to do all the washing up for all meals." Another staff member said, "It does take our time away from supporting people." We felt the base of plated hot desserts and found they were cold. We discussed this with the staff member and they said, "We'll warm them up if people still want them." This showed us washing up tasks, in some dining areas, were put ahead of supporting people with their meal. We discussed this with the registered manager and they said, "We can get a dishwasher and change how that happens."

In another dining area, we observed some staff were not well organised and people's dining experience was not relaxed. We saw the television was left on, although none of the people were watching it. For people with dementia noise can be distressing and disorientating. Three different staff members came in and out of the dining area at various times, but no one staff member remained in the dining area to support people. We saw one person was given their meal before two other people. This caused one person to become anxious and put their hand into the other person's meal to eat it. One staff member returned to the dining area and told the person, "No, yours is coming soon." We asked why people were not served their meals at the same time to avoid people becoming confused and were told, "Normal diets and soft diets arrive at different times." This was an example of how staff lacked the dementia care knowledge they needed for their job role that we observed.

We observed one person was not offered the support they required to eat their food when their care record said they 'required assistance to eat.' Staff were not consistently present in the dining area to offer support. The person tipped their drink into their dessert and one staff member told them, "I'll get you another one." We saw no replacement dessert was offered to them. We asked the staff member about this and they told us, "Another staff member told me it means they don't want it." We observed a few people walked away from their meals and although guided back by staff, staff did not consider what may make them act in this way the impact, for example the noisy environment on people. A person with dementia may walk

away to try to remove themselves from an overstimulating situation. This showed us although people were offered nutritious meals, they did not always effectively or consistently receive the support they needed to eat and drink in a calm environment.

A few people were able to tell us they enjoyed the homemade cakes with afternoon tea. Although we saw people were offered drinks and snacks between their meals at set times, we found most people did not have drinks accessible to them during the day. One person asked us for a drink and we saw they had no means to summon staff to ask for this themselves. We saw some people had not been offered drinks with meals which meant they might be thirsty. We discussed this with staff and one staff member told us, "We don't tend to leave drinks with people because someone else might drink it." Accessible drinks and consistent support to drink would ensure people are able to drink whenever they are thirsty.

Relatives spoken with felt confident that staff would ask for a GP visit if their family member was unwell. One relative said, "I do feel staff would get the doctor if needed, I have no doubts about that." Staff told us if they thought someone was unwell they would tell the manager and they would arrange for either a nurse or GP from the surgery to visit them. Records showed that healthcare professionals were involved and gave guidance to staff. One record showed us a referral had been made to speech and language therapy for a person with swallowing difficulties. Another record showed a referral had been made to physiotherapy for one person. This meant people were supported to maintain their health and visits from healthcare professionals were requested when needed.

Requires improvement

Is the service caring?

Our findings

We observed some kind, respectful and friendly interactions between staff and people living in the home. In one lounge, we saw staff sat with people and engaged them in conversation. We heard one staff member ask a person about their recent outing and saw the staff member encouraged others to join the conversation. One person told us, "We are the best of friends." Another person said, "Staff are very kind." Staff commented to us they thought caring for people meant, "Making people feel comfortable." And, "Treating people as individuals." However, we found although care staff were friendly in their approach, most communication with people was when staff were offering support or completing a care task. Some staff did not always take opportunities to engage or communicate with people. For example, one staff member arrived on shift and greeted another staff member but did not greet people in the same communal lounge area. We saw some people received limited stimulation and interaction, which they may have enjoyed.

We found that whilst staff knew how to maintain people's privacy and dignity with personal care tasks, we did not find this happened consistently and some people's care needs were not met. One relative told us, "I always find my family member clean and tidy in their appearance." We heard one staff member offer support to one person who needed help with a tissue, helping them to maintain their dignity. Most people had been supported by staff with their personal hygiene needs and to choose clothing appropriate for the time of year. However, we found some inconsistencies with how people's care was delivered. We saw a few people that had no slippers and / or socks on. We asked one person if their legs and feet were cold and they repeated 'cold' to us. We gently touched their skin which was very cold. We discussed this with the registered manager and heard them ask staff why people had no slippers or socks on. Staff did not offer any explanation but went to fetch slippers or socks for people. We saw staff collected mealtime crockery from one person's bedroom, but they did not return to wipe food debris from the table and the person was left with some food spillage on their clothing.

We asked staff how they ensured people's privacy was respected. One staff member said, "I'd always make sure the door was closed if I needed to carry out personal care needs." We observed one staff member discreetly spoke with one person telling them, "We need to go to your room to help you get freshened up."

None of the people we spoke with could recall being involved in decisions about their care. One person told us, "I've never felt involved." The registered manager told us two people's relatives had enduring power of attorney but we did not see any record of this in the person's care record or how their relative was involved in their family member's care decisions. None of the relatives we spoke with could recall being asked for their views about the service. One relative said, "I've never been asked my views on behalf of my family member." One staff member told us, "We used to send surveys to people and their families but this has been overlooked and has not happened for several years."

Requires improvement

Is the service responsive?

Our findings

We observed whether staff were responsive to people's needs. We saw one staff member ask if one person was comfortable in their armchair and if they would like the recline position adjusted. The staff member made the person more comfortable and we heard the person tell the staff member "that's better, thank you." We saw another staff member gently use their arm to protect and adjust the position of one person who was leaning over the side of their chair.

Although we saw one staff member responded to a person who was calling out for support, we found no one had a call bell accessible to them. We asked people how they would get help if they needed it. One person said, "I'm lucky because I can go and ask, but lots of people here can't do that." A further two people said, "We'd have to wait for someone to go past us." One staff member told us, "Some people would not be able to use a call bell, so we just check on them often." We saw some people that would be able to use a call bell did not have one available to them which meant they were unable to summon staff assistance if needed. We discussed this with the registered manager and director. The director told us, "We can put call bell cords where needed."

One staff member told us, "We do regular checks on people who are cared for in bed." Although we saw such checks took place, the checks undertaken by staff may not always have been responsive to people's needs. For example, we saw one staff member looked in one person's bedroom but did not spend any amount of time with the person, speak with them or offer them a drink on their 'check'. We spoke with the staff member and asked the purpose of the checks and they said, "To make sure the person is okay." We found people receiving such 'checks' had little or no verbal communication and a high level of support need.

People and their relatives told us they had not contributed to the planning of their care. Relatives said they had not been invited to attend care reviews. One relative said, "Staff cannot always update me about my family member and how they are. I've never been invited to give feedback for a review or attend a review of their care." We found very little or no information about people's life history, their preferences or how they liked to spend their time. We found care was planned without people's or relative's involvement. People at the home were living with dementia and most unable to tell about themselves. As a result staff had little or no information about people so were unable to plan how their care was delivered based upon their previous interests.

We looked at care plans to see how people's specific health care needs were identified and monitored. We saw one person's care record showed their blood pressure was monitored daily by staff, but staff spoken with were unable to tell us why this was done. We asked the registered manager about this and they said they were unsure of the reason but details should be in the person's care plan. We found no information in the person's care record to tell us why or what the reading should be or when healthcare guidance should be sought.

The care records for two people who had diabetes lacked information about managing their individual diabetes and for one person there was no diabetes care plan. Staff told us district nurses visited to administer insulin injections for a few people and staff at the home gave tablets to a few people for their diabetes. Staff spoken with said if they were concerned about someone they would inform whoever was in charge. Although one senior staff member had limited knowledge about managing diabetes, all senior staff told us they would check the person's blood sugar level and explained the technique to us. Staff said if the reading was not 'normal' for the person they told us they would phone the person's GP for advice.

We looked at how people spent their time in the home. One staff member told us, "People have a type of church service every few weeks if they wish to go to it." The registered manager said, "If people wish to practice their faith then we will arrange for some one of their faith to come." One person told us, "I am so bored here. Nothing to do and no one to speak to." One relative said, "I do feel there could be more in the way of activities. I know they do get people in on occasions, but just on a day to day basis it would be good for more to be going on for people." Staff told us there were no planned daily activities and no designated staff member for activities. One staff member told us, "Big events are planned for like having a fete or someone coming in to the home like a singer, but otherwise activities happen when care staff can do them with people. Today, the manager has arranged for a carer to come in to do some activities with people." One staff member told us, "I've been doing one to one hand massage with some people." We saw another staff member

Requires improvement

Is the service responsive?

playing a board game with two people. We saw some people were in communal areas with televisions on, but were either asleep or not watching the programme. We discussed this with staff and one staff member said, "We often try to find old films on the television for people or put on soft music." One staff member told us, "Activities happen but are not planned. They don't really meet people's needs. We try to do one to one things with people but more allocated staff are needed for activities and planning around what would be good for people." Although we observed some activities took place with some people, overall we found most people were not asked what they would like to do.

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 no complaints. I'm happy my family member is here." Relatives we spoke with told us they were not aware of any meetings for relatives and had not been asked for their feedback.

Inadequate

Is the service well-led?

Our findings

At our inspection in November 2014, we found that the registered manger had not provided sufficient managerial oversight of the home. At the time the registered manager told us she has spent less time at Chasewood Lodge as she needed to provide more time at the provider's other home where she is also the registered manager. As a result some actions had not been taken as required; for example notifications about specific incidents and duties delegated to junior staff such as qualify audits, had not been carried out effectively. At this inspection, we found that staff delegated to send notifications about specific events, for example about accidents, had been doing this and understood their role and responsibility. However, audits to monitor the quality of the service provided were still ineffective and insufficient improvements made. We found a number of examples during the two inspection days which had not been identified by the manager or the provider from their own audit processes.

For example, they had not identified that people did not have call bell cords, that some equipment was unsuitable or that staff had failed to support people to put on socks / slippers. The registered manager told us they had not noticed there was no signage telling people about the closed circuit television. This showed us informal checks were not effective to identify issues that required improvement and therefore did not provide staff with effective leadership.

We asked the registered manager how they now divided their time between the two care homes. They said, "Generally, I am based at this home now. I have two deputy managers here that I can delegate to." Staff told us that most days the registered manager spent time at Chasewood Lodge. The registered manager said, "I always have a walk around the home." One staff member told us, "The manager does have a walk around the home to check things are okay." We observed the registered manager spent time on the units and also saw the provider of the home talking with some people in one communal lounge. We observed people were relaxed during these interactions which showed us the registered manager and provider were known to staff and people living there.

Some quality assurance processes were in place but we found these were not effective. The most recent infection control audit was completed on day one of our inspection and had not identified some of the issues we had observed. For example, we found soiled incontinence pads had been placed directly into a bin without first being sealed in a bag. This led to an unpleasant odour in one communal bathroom. Staff used tea towels to dry crockery and saw staff had placed some over the rim of kitchenette cupboard doors where seals were not always intact. We looked in one kitchenette cupboard and saw staff used it to store their outdoor coat along with an unused incontinence pad and cleaning items such as washing up liquid. We saw unused incontinence pads stored uncovered in one person's ensuite. These issues presented risks of cross infection that this audit, nor previous infection controls audits, had not identified.

There were arrangements in place for some medicine checks but we found medicine errors were not always identified. We looked at a medication audit and found the audit had not identified issues we had found. For example, we found controlled drugs did not correspond with records. We looked at the home's monthly audit completed in October 2015 by senior staff and saw the home had scored itself 'very good' where we found improvement was required. There was nothing to demonstrate that the registered manager checked the effectiveness of the audit delegated to senior staff members.

Accidents were recorded for each unit and one unit for October 2015 recorded 20 accidents for eight people. Accident forms were completed for all observed accidents and a senior staff member told us where an injury was sustained by a person, but not observed, an incident form was completed instead. One staff member told us monthly accident audits / analysis were completed for each unit to look for trends and patterns so that actions could be taken to reduce the risk of reoccurrence. This was completed by a senior staff member. The analysis seen lacked detail as to which person / people had accidents and did not record the times and places where accidents had occurred. The senior staff member had concluded 'no trends', but as some important information was not available or had not been considered, the analysis was not effective. There was no identified action plan to consider how the number of accidents could be reduced.

The registered manager told us staff had completed the necessary training required to give them the skills to care and support people that lived at the home. Most staff confirmed to us they had completed training and records

Is the service well-led?

confirmed this to us. However, we found staff knowledge had not been sufficiently checked by the registered manager or provider. For example, our observations of some staff communication and the care offered to support people living with dementia were not effective. A further example was the inconsistent responses staff gave us when asked about their action in the event of a suspected fire at the home.

We found audits to assess and monitor the quality of the service were delegated to senior staff members to complete. We saw no evidence to show us the registered manager checked audits to ensure they were an accurate reflection of the home. We asked the registered manager how they checked staff competencies. They told us this was done informally when they walked about the home. They said, "If I saw something that needed addressing, I'd address it." We found staff did not always have the skills or knowledge to complete some tasks delegated to them.

We asked to look at feedback from people and their relatives about their experiences of using the service. One staff member told us, "We are planning to introduce feedback from people again, this was last done in 2011. It just hasn't been done since then. "

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

We saw improvement had been made, following our last inspection in November 2014, to store people's personal information and access to them was restricted to authorised staff.

Staff told us they felt supported by the registered manager. One staff member said, "The manager is approachable." Another staff member said, "Once I asked if we could have resources for activities and they sorted out an indoor bowling set for us to use with people." Staff said they had team meetings and felt they had the opportunity to say what they wanted and were listened to. One staff member said, "The manager always listens, though sometimes they may not always be able to do things we suggest due to costs." One staff member said, "We also now have one to one meetings. These stopped for some time but have started again this year." We found staff felt supported by one another and the management of the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12 (1) Care and treatment must be provided in a safe way for service users. 12 (2) (g) The provider did not always have a proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12 (1) Care and treatment must be provided in a safe way for service users. 12 (2) (b) (c) The provider did not always do all that was reasonably practicable to mitigate risks to service users. The provider did not always ensure that persons providing care or treatment to service users did have the qualifications, competence, skills and experience to do so safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent 11 (1) Care and treatment of service users must only be provided with the consent of the relevant person. 11 (3) If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act. The registered person had not always acted in accordance with the requirements of the Mental Capacity Act 2005.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17 (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 17 (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular , to - (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services) and (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. The systems and processes in place did not always achieve this.

The enforcement action we took:
Warning Notice