Healthcare Homes (LSC) Limited

The Chase Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was carried out on 6 June 2017 and was unannounced. This was the first inspection since the provider registered with us in February 2016.

The Chase Care Centre provides accommodation for up to 110 older people, including people living with dementia and younger people with complex health need. The home is registered to provide nursing care. At the time of the inspection there were 105 people living there.

The service had a manager who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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.

People's medicines were not managed safely and risks to people's safety were not always sufficiently mitigated. Staff knew how to identify and respond to concerns of abuse. We also found that person centred care, engagement and activities was an area that was lacking on some of the units.

People were supported by sufficient numbers of staff who were safely recruited. The staff told us that they felt well trained and received a good level of support.
People's capacity to make decisions was assessed and consent was sought. People were supported to eat and drink but the mealtime experience needed improving. People had access to health and social care professionals as and when it was needed.

People were not always treated with dignity and respect. We also found that confidentiality was not always promoted. Interactions between staff and people needed to be improved. However people told us that staff were kind.

People's personal care needs were being met but their emotional wellbeing was not always promoted. Care plans were in place but not always followed. Activities provision required further development to ensure people had sufficient opportunity for engagement.

There was a quality assurance system in place. However, although these had identified issues, they were not all yet resolved. Some of the issues unresolved meant that there was a breach of regulations.

The registered manager was new to the service and was working through an action plan they had developed to address the issues they had found. People and staff were positive about the registered manager. We found that formal complaints were responded to.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People's medicines were not managed safely.

Risks to people's safety were not always sufficiently mitigated.

Staff knew how to identify and respond to concerns of abuse.

People were supported by sufficient numbers of staff who were safely recruited.

Is the service effective?

Good

The service was effective.

People were supported by staff who were trained and supported.

People's capacity to make decisions was assessed and consent was sought.

People were supported to eat and drink but the mealtime experience needed improving.

People had access to health and social care professionals.

Is the service caring?

Requires Improvement

The service was not was consistently caring.

People were not always treated with dignity and respect.

Confidentiality was not always promoted.

Staff did not always interact and engage with people positively.

People on the ground floor unit told us that staff were kind.

Is the service responsive?

Requires Improvement

The service was not responsive.

People's personal care needs were being met but their emotional wellbeing was not promoted.

Care plans were in place but not always followed.

Activities provision required further development to ensure people had sufficient opportunity for engagement.

Formal complaints were responded to.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was a quality assurance system in place. However, although these had identified issues, they were not all yet resolved.

Some of the issues unresolved meant that there was a breach of regulations.

The registered manager was new to the service and was working through an action plan they had developed to address the issues they had found.

People and staff were positive about the registered manager.

The Chase Care Centre

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2014 and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us.

The inspection was unannounced and carried out by three inspectors and an expert by experience. An expert by experience is someone who has used this type of service or supported a relative who has used this type of service.

During the inspection we spoke with nine people who used the service, two relatives, 13 staff members and the registered manager. We received information from service commissioners and health and social care professionals. We viewed information relating to seven people's care and support. We also reviewed records relating to the management of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us due to their complex health needs.

Requires Improvement

Is the service safe?

Our findings

People's medicines were not always managed safely. We saw that some people had specific ways to take their medicines which included being given covertly. For example one person had their medicine crushed and they took it with a spoonful of yoghurt as agreed by their GP and family members. There was a risk assessment and plan in place to help ensure this was managed safely. We also found that there was a staff signature list and guidance for staff on safe medicines practice.
However, we found that this practice was not always followed and witnessed unsafe medicine administration practice on one unit. For example, a nurse dispensed tablets for four people into individual pots and left them in clear view on the top of the open drugs trolley in a busy dining room at breakfast time. The nurse went to the other side of the dining room to assist a person take their medication, however they did not have a clear view of the trolley and would not have seen if anyone accessed the trolley. In addition the medicines on top of the trolley were not labelled to identify the person to whom they were prescribed. This increased the risk of a person being given the wrong medicines.

We checked a random sample of boxed medicines and controlled medicines. We found that stocks of some boxed medicines did not always agree with the records maintained. For example, there were too many or too few when checked against the number of tablets received and signed as being dispensed.

We noted that one person had a box of controlled medicines in their room, not locked away as they are required to be. They told us that they liked to administer their own medicines and it varied the amount that they took. We found that this was not a safe way of managing these medicines and needed to be reviewed to protect the person and others who may have access to the medicines.

Therefore due to the issues found in relation to medicines management, this was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff were aware of how to recognise and respond to allegations of abuse. Information and guidance about how to report concerns, together with relevant contact numbers, was displayed in the home and was accessible to staff and visitors alike. Bruises and skin tears were appropriately investigated and recorded to help ensure that trends and patterns could be identified to avoid recurrence. However, we had some safety issues reported to us that were not always recorded and actioned. For example we were told of unsavoury people in the building at times when there were lower staffing levels to supervise. In addition a person had stated that another person who also lived at the home had threatened them with a knife. The registered manager considered that this may have been triggered by recent events in the news. However they had not notified us of this allegation and had not referred the concerns to the safeguarding team. One person told us, "I really can't say that I feel safe anymore." They told us this was due to some of the other people living at the home.
The registered manager acknowledged that some people's mental health conditions were a concern and had made referrals for further assessments to be made as she considered the placement may not be right for their needs. The registered manager also stated, "Staff need extra support around mental health needs." We found that although the registered manager was aware of these issues and made the appropriate

referrals to seek support with these challenging situations, however at the time of the inspection there was not a clear plan in place to ensure people felt safe and were protected from harm. Following the inspection the registered manager sent us a plan which detailed how they would ensure people's safety in the home in relation to some of the other people who lived there and their visitors. However, although the registered manager and staff were aware of how to maintain people's safety, systems documented required improvement to ensure the consistency.

Where potential risks to people's health, well-being or safety had been identified, these were assessed and reviewed regularly to take account of people's changing needs and circumstances. Risk assessments were in place for such areas as the use of bed rails, use of oxygen, falls and mechanical hoists. These assessments were detailed and identified potential risks to people's safety and the controls in place to mitigate risk. We noted that people who had been assessed as requiring bedrails on their beds to prevent them falling had protective covers over the rails to reduce the risk of entrapment.
Accident and incidents were reviewed by the registered manager to help ensure or remedial actions had been completed. They also used this review to identify any themes or trends.

We checked a random sample of pressure mattresses for people who had been assessed as being at risk of developing pressure ulcers and we found that they were at the appropriate setting for their weight. Staff told us that people were assisted to reposition at appropriate intervals to help maintain their skin integrity and we saw that records were maintained to confirm when people had been assisted to reposition.

People were supported by sufficient numbers of staff. One person said, "In my opinion there are enough staff." Throughout the course of the day we noted that people received their care and support when they needed it and wanted it. Call bells were answered in a timely manner and staff went about their duties in a calm and organised way. Staff also told us that they felt there were enough staff. One staff member said, "There are enough staff, the level is good."

The registered manager reported that there were four nurse vacancies currently with an additional two needing to be covered due to staff suspension during the disciplinary process following safeguarding allegations. They told us that they covered this with agency staff. Staff told us that shifts were usually covered. One staff member said, "There is enough staff, we sometimes use agency."

Safe and effective recruitment practices were followed to make sure that all staff were of good character and suitable for the roles they performed at the service. We checked the recruitment records of three recently recruited staff members and found that all the required documentation was in place including two written references and criminal record checks.

Good

Is the service effective?

Our findings

People were supported by staff who had been appropriately trained and received supervision. One staff member told us, "They provide all the training we need. I've recently trained in dementia, phlebotomy and manual handling." Another staff member told us, "I recently did manual handling training, first aid, food hygiene and health and safety." We saw that training and supervisions were up to date. This was monitored by the registered manager.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met and found that they were.

We noted that where people did not have capacity to make decisions about their care and support needs meetings were held with relatives and health professionals as appropriate to ensure that any decisions were made in people's best interests.

In some instances we noted that staff explained what was happening and obtained people's consent before they provided day to day care and support. For example, on one unit during the lunch service we noted staff asking people if they had finished and if they needed assistance to remove their clothing protectors. One staff member asked a person, "[Name] I will take you to the lounge now so that you can watch TV."

'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) decisions were in place, and it was clear that people had been involved with making the decisions and, where appropriate, their family members as well.

People received appropriate support with eating and drinking. We observed the lunchtime meal served in a communal dining room and we noted that people were provided with appropriate levels of support to help them eat and drink. This was done in a calm and efficient way which meant that people received their meal in a timely manner. However, staff did not interact with people and we considered this was a missed opportunity for staff to spend quality time with the people they supported.

There was a menu on display in all units, some were on a chalk board on the wall and others on the tables. One person who used the service told us, "They come around the day before and ask me what I want from the menu." We noted that when the meal was served people were not given a visual choice, this meant that people who were living with dementia may not have remembered what they ordered the previous day and therefore did not know what they were eating. One visitor told us that their relative wasn't able to verbalise

their choices so unless they were visiting often ended up with the same foods as they didn't know what else to ask for.

We asked the chef about the arrangements for food options for people living with diabetes. The chef said, "The main course options are suitable for all the people who use the service, I make separate desserts for people who are diabetics." However on the day of inspection the diabetic alternative was a yogurt. The registered manager told us that they intended to arrange for an external resource to review the menu and look at the food generally including people's meal time experience.

Assessments had been undertaken to identify if people were at risk from poor nutrition or hydration. We noted that these assessments were kept under review and amended in response to any changes in people`s needs. For example, one person had experienced weight loss and had been referred to a dietician and speech and language therapist. The staff team followed the advice and guidance received as a result of the referral and the person's weight had returned to within a health range. The person and been discharged from the dietician as a result.

People had regular access to health and social care professionals as needed. We noted that appropriate referrals were made to health and social care specialists and there were regular visits to the home from dieticians, opticians and chiropodists.

Requires Improvement

Is the service caring?

Our findings

People who were able to speak with us, mainly on the ground floor unit, were positive about the staff. One person said, "They are all very kind, helpful, understanding. They will help me with shops, if I need something, all I have to do is ask. Very nice people, and I cannot single out one of the other-all of them are superstars." Another person told us, "Staff are very helpful."

However, we noted that the interactions between staff and people differed depending on which unit we were on. On some units we heard staff being cheerful, chatting and explaining what they were doing. On other units, predominantly for people living with dementia, this was not the case. Staff went from task to task with little interaction. For example, staff prepared people's drinks for them and then presented them whilst bluntly telling them, "Here is your tea." We didn't hear the staff ask people if they would like a drink or what drink they would prefer. We overheard staff speaking to each other when in a bedroom providing personal care and we saw staff move people in wheelchairs without asking if that was ok or even telling them what was happening. We also observed one staff member supporting a person who was living with dementia to walk. When the person got distracted, the staff member put their hand on their lower back and said, "Move." There was no encouragement or chatting or explaining that they were heading to breakfast. We noted that this was a reoccurrence when supporting people living with dementia, staff seemed to want them all sitting in the lounge and when they left the lounge to wander around, staff ushered them back. This was an area that required improvement.

We observed some instances where people who used the service had difficulty in communicating with the staff that supported them. For example, one person became extremely frustrated when they asked a staff member what the dessert was and could not comprehend the answer that was given. This was because the staff member, whose first language was not English, had responded in a strong accent and the person could not understand what was being said to them. This was an area that required improvement.
The environment varied throughout the home. Some areas were warm and welcoming and some people's individual bedrooms were personalised. However, some areas were shabby and gloomy with no atmosphere, pictures and murals painted on the walls did little to cheer up the environment.
There were photographs of the staff team on display in the communal area of the home which meant that visitors and relatives were able to identify the staff on duty. Relatives and friends of people who used the service were encouraged to visit at any time and we noted from the visitor's books that there was a regular flow of visitors into the home.

People's dignity was not always promoted. For example, throughout the days we saw that all people's room doors stood wide open if they were in bed. Where people had urinary catheter bags these were positioned in clear view of the door. This made it easy for staff to monitor however, did not promote people's dignity when visitors walked past their rooms. This was an area that required improvement.

We spoke with the registered manager about the issues were found. They had already identified these concerns and had added remedial actions to their action plan. There were plans for dignity training and more supervision of the staff team to ensure they worked to the registered manager's expectations.

However, the lack of interaction, engagement and personhood for people was an impact on people's wellbeing. This meant this was a breach of Regulation 9 of the Health and Social Care Act (regulated Activities) Regulations 2014.

People's involvement in the planning of their care was an area that was being developed. Some plans included information and a record of people's or their relative's involvement, however, this was not consistent. People were unable to tell us if they had been involved. One person told us that they did speak with the registered manager about their needs and felt listened to. One staff member told us, "I want communication with relatives to be improved." Another staff member told us, "We get to know people from our observations and the communication and team work."

People's care records were stored in a lockable office in order to help maintain the dignity and confidentiality of people who used the service. However, we noted that the office was not always closed when staff were not using it and we saw personal and private information about people left in communal areas. This was an area that required improvement.

Requires Improvement

Is the service responsive?

Our findings

People's care plans were sufficiently detailed to be able to guide staff to provide their individual care needs. Care plans were reviewed regularly to help ensure they continued to accurately reflect people's needs. However, we noted that care plans were not always followed. For example, one person's plan stated that being alone caused them anxiety. We saw this person for over an hour on their own, in their room, unsupervised with a lap belt, becoming more and more anxious. This person had limited communication and had no means of calling for help. Later in the day when they were in the communal room, they were relaxed and asleep.

People's personal care needs were being met. One relative told us, "They are doing a wonderful job looking after [person], so attentive, they can see if [person] is under the weather always check if [they are] too cold or hot, they make a notes of everything, nurses are brilliant here." Staff also felt that people's care needs were being met. One staff member told us, "If we have a good handover in the morning we can make sure we can make the improvements and help people with what they need." However, needs such as activities and therefore their wellbeing were not always met.
People sat around all day on the day of inspection, staff that were with them either sat not talking or stood in lounge doorways. People who were living with dementia were not given anything to do to stimulate their minds. When they were walking around, staff did not trying to engage and make the walk purposeful but encouraged them to sit down. There were limited items around such as games or interesting objects for people to pick up or use. We saw some items around the home to facilitate engagement and stimulation including books, videos, piano, hairdressing salon, café and games however staff did not use them to encourage people to get involved in an activity. In addition the environment lacked a dementia friendly theme for those who would benefit from it.

There were photographs on display depicting a variety of activities taking place however; on the day of this inspection we did not witness any activities taking place in the home. One staff member told us, "Activities are good. Dominoes and hat making yesterday. Out and about with people to places. We take one person to [supermarket]." However throughout the inspection people were in communal areas of the home with staff members in attendance but there were no opportunities for engagement provided. We noted this had a negative impact on some people who started to become anxious and frustrated. The registered manager told us that there had been no activities that day as some people had gone out with the activities organiser to buy plants for the garden. They showed us an activity log of different activities offered in the home. This included a weekly newsletter which offered reminiscence and quizzes. This included a prompt for a singalong. However, many staff were focused on task delivery and did not have the openness to recognise or deliver what an impromptu activity might be. This as a result meant that for long periods of time people did not have any meaningful activities to participate in.

Therefore, this lack of activity coupled with the lack of interaction, engagement and personhood for people was an impact on people's wellbeing. This meant this was a breach of Regulation 9 of the Health and Social Care Act (regulated Activities) Regulations 2014.

Formal concerns and complaints raised by people who used the service, their relatives or other stakeholders were appropriately investigated and responded to in accordance with the provider's policy and procedure. However, we found that where people who used the service had raised concerns verbally with the management team they were not always recorded and no outcomes were recorded. The registered manager addressed these smaller issues but they did not keep a record of them, which would help them identify themes and trends. This was a something they told us that they would develop.

We saw that the registered manager had met with a complainant to help resolve issues and there had been relatives meetings to gain their feedback. There were resident and relatives meetings were people had the opportunity to share their views and be kept informed of changes in the home. The service had recently sent a survey out and they were awaiting the responses to this.

The service received several compliments which praised that staff, management and quality of service that people had received.

Requires Improvement

Is the service well-led?

Our findings

There were systems in place to monitor the quality of the service. There were a series of audits and checks carried out regularly to help identify and resolve issues identified. There had also been an external audit had been conducted in March 2017. However, the registered manager joined the service in March 2017 and had conducted their own audit and an action plan was developed in response to this which incorporated the findings from the external audit. The registered manager was working through their action plan to address the issues they had found. These issues were similar to the issues we found as part of the inspection. This demonstrated that the registered manager knew what was going on in the home and had already started work to resolve the issues. However, due to the early stages of their plan and the short amount of time they had been at the home, these had not yet been resolved. This had resulted in some areas being in breach of regulation and therefore was an area that required improvement.

We found the registered manager to be very knowledgeable about the service that they were running. The registered manager demonstrated an in-depth knowledge of the staff they employed and people who used the service. The registered manager told us that the staff were, "A fantastic staff team, they really want to learn." They were familiar with people's needs, personal circumstances and family relationships. Throughout all our discussions they were able to tell us about specific issues in details and recall what had been happening to address it. They knew about people's hospital appointments, ill health and other detailed information. This was a testament to their dedication to getting the service running to their expected standards and to comply with regulation.

People were positive about the registered manager. One person said, "The [registered] Manager is very nice. Can talk to her anytime. She is very caring." Another person told us, "I know she just started three months ago, and I know she made some progress. She is easy to talk to, her office is just down the corridor, she is aware what [any issues raised by the person] I said." Staff were also positive about the registered manager. One staff member said, "I've approached the manager since she started and have spoken about some concerns. I think she has listened and taken the points on board." Another staff member said, "We have a lovely manager." A third staff member said, "The home and the management are doing well and what they need to do."

Staff told us that they were keep informed and up to date with changes. One staff member said, "We have team meetings, unit meetings and individual meetings." Other staff told us that they had thorough handovers and this helped ensure they had the relevant information to enable them to support people appropriately and be informed of any lessons learned from recent events.

The day following the inspection visit the registered manager informed us that in response to issues raised by us they had taken immediate action to address the shortfalls. This included assessing medicines competency, holding a staff meeting and arranging training the following week.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive consistent person centred care, sufficient engagement and interaction.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines were not managed safely.