Chase Lodge Care Home Limited

Chase Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 6 September 2018. The inspection was unannounced. At our last inspection in May 2016 we rated the service as good. During this inspection we found breaches of regulations 9,12,15, 17 and 18. These related to the lack of person centred records, unsafe care and treatment, lack of effective systems to monitor the service, out of date records, and lack of appropriate support to staff.

Chase Lodge Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care service accommodates up to 21 people. At the time of our inspection 21 people were living at Chase Lodge Care Home, however two people were currently in hospital. The service specialises in providing care to people living with complex mental health needs.

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Appropriate governance arrangements were not in in place to monitor and improve the service. Errors we found during our inspection had not been identified when the limited audits in use had been applied to the service. There was no evidence of the provider or registered manager regularly auditing the service.

We found there were unsafe practices in managing the administration, storage and disposal of people's medicines.

People were sometimes put a risk of unsafe care as records were out of date or inaccurate. We found the involvement of people in the service was limited. Whilst there had been 'Residents' meetings, there had been no surveys for people or staff to complete about how the service was run.

The provider did not have an effective system to review incident and accident records and therefore could not always identify actions to reduce potential risks to people using the service.

Risk assessments were not updated when there was a change in the person's support needs. The provider had a range of audits in place but some of these were not effective and did not provide appropriate information to enable them to identify any issues with the service and act to make improvements.

Staff had not been supported with regular supervision and appraisals. There had been no regular meetings for staff.

During our inspection, we found that the service needed tidying, decorating and some repairs were required

especially in the bathrooms. Some infection control practices around laundry procedures needed to be addressed.

We found there were few up to date mental capacity assessments in people's files. This meant the provider did not always meet the requirements of the Mental Capacity Act.

Most of the people we observed spent long periods of time watching the tv, either in their rooms or in one of the lounges. We did not observe people engaged with meaningful activities

Staff employed in the making of meals knew what food people liked to eat. The kitchen was clean with daily, weekly and deep clean practices in place.

People positive comments to us about the caring nature of the staff. Staff protected people's privacy .

People confirmed there were sufficient staff to meet their needs. There were systems in place to safeguard people from abuse and the recruitment of staff was safely completed to make sure that they were suitable to work in the service. Staff were aware of their responsibilities and knew how to report any concerns.

The registered manager was experienced and was supported in their role by the provider. People who used the service and staff described the registered manager as approachable and supportive. The provider worked in partnership with other relevant agencies to assist in meeting people's needs. Staff understood about the need for confidentiality. Records were locked away and were inaccessible to other people.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Medicines were not always managed safely.

Risks to people were not up to date and plans were not in place to guide staff in providing care safely.

People were not always protected by the prevention and control of infection.

There were enough staff to care for people safely.

Staff understood their responsibilities about safeguarding people from abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

People's needs were not always assessed before they moved into the service.

Staff were not consistently receiving supervision and appraisal to support their development.

Staff were not always working within the principles of the Mental Capacity Act 2005.

Staff received training appropriate to their role.

People were supported to eat and drink to remain healthy.

Is the service caring?

Good

The service was caring.

People using the services told us they liked the staff and found them caring and kind.

Staff treated people with kindness and patience and knew people well.

People looked well cared for and their privacy and dignity was respected and maintained

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans had been developed, but these had not been reviewed regularly with the involvement from people.

People told us that activities during the day were limited and staff did not have time to sit with people and encourage them to participate in an activity of their choice.

People's care needs at the end of their lives had not been considered and care plans contained little information about their end of life wishes.

There was a complaints policy in place. People knew how to raise concerns.

Is the service well-led?

Requires Improvement

The service was not always well led.

Systems were still not in place to monitor the quality of the service.

Records in the service were not always up to date or accurate.

A survey to collect the views of people and staff had not been carried out.

People and staff spoke positively about the registered manager and provider.

Chase Lodge Care Home

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.'

This inspection took place on 6 September 2018 and was unannounced. The inspection was carried out by two adult social care inspectors, a specialist adviser who was a registered mental health nurse and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

During our visit we spoke with the registered manager and three staff members. We spoke with seven people who were living at the service. We tried to contact external professionals for feedback but did not receive any.

We did not use the Short Observational Framework for Inspection (SOFI) as everyone we spoke with was able to tell us about their experiences. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at care plans and associated records for six people. We looked at staff duty rosters, feedback questionnaires from relatives, quality assurance records, records of compliments and complaints, accidents and incidents, seven staff recruitment files and the providers policies and procedures.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always managed safely. There was a process in place for checking the medicine administration records (MARs) to ensure all medicines had been signed for; however, this system was not effective because we saw signature gaps in MARs. We brought this to the attention of the registered manager who had not identified these omissions. We found that these weekly audits, had been undertaken intermittently over the past three months. The audit had highlighted that on two occasions one person had some tablets missing. This had been passed to the registered manager. The registered manager told us that the GP had not prescribed enough. However, due to the lack of a process to check medicines at the time they were received into the service, it was difficult to evidence that this was the reason for the missing medicines. This resulted in the person not having his prescribed medicines on at least two occasions. We could not find any evidence that medical assistance had been sought to see if this had placed the person at risk.

Some people had been prescribed creams. It is good practice to have body maps to guide staff where to administer which creams. We found body maps had not been completed to support this. The registered manager told us that they would start doing this straight away.

Some people had been prescribed additional medicines on a PRN (as required) basis There were no protocols in place to inform staff when these medicines were required and information about the safe administration of these medicines for the person concerned.

There was no master signatory list for the MARs. Having such a list would enable the registered manager to identify what staff member had given medicines to people on what day. Most MARs were pre-printed and contained relevant information about people. However, we found two handwritten MARs that only contained the persons' name and no other details. There were no photographs on the MARs. Photographs are used on MARs to help staff to ensure people are given the right medicines.

One person was prescribed Digoxin. There was a record sheet for their pulse to be taken with the MAR, this was not being completed. It was not clear whether the pulse check prior to administering the medicines should have been completed. The same person also had two medicines still being written on the MAR despite both being discontinued some time ago.

Two people were prescribed a medicine that required specific ongoing monitoring. There was no care plan for either person, particularly in respect of what to do if the person for example, becomes unwell over a period of a few days or declined to take the medicine. Staff had not been trained or made aware of these issues.

There were medication policies, however these were last reviewed 2011/12. The administration policy was illegible due to poor photocopying. The registered manager assured us that they would rectify this immediately.

Risk assessments had not been undertaken and there were no details of specific management arrangements. Some fire doors in the service service were being held open by chairs; not only did this practice create a risk that in the event of a fire the doors would not automatically close but it also caused a risk of people tripping on a door wedge or a chair that was holding door open. We saw that one person almost fell to the floor after tripping over a chair. One flight of stairs in the service had no handrail for part of the stair well and this posed a risk to people using the stairs, especially those with mobility problems. There was a portable bath seat available in the service but there was no detailed guidance or specific staff training about how it should be used to safely support a person, and we noted in one care plan that a person used this when bathing

The registered manager did not know when the last pharmacy visit and check took place, though they said they would contact their new providers to arrange one.

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

People told us that they were receiving the help they needed with their medicines. One person said, "I take [my medicine] twice a day and yes the staff watch me take it and I don't refuse it as it is doing me good". One person told us, "Staff give it to me and I take it when I need it". No one in Chase Lodge managed their own medicines and had signed saying that is how they preferred it. All staff who administered medicines had recently had their competency checked to make sure they were still safe to do so.

The service did not consistently ensure that national standards in respect of infection control were maintained. Although the communal areas of the service, including the kitchen were clean toilets and bathrooms posed some hygiene risks to people. We noted that few had toilet roll holders, none had paper towel dispensers (paper towels were left on window ledges or on top of toilet cisterns). We saw that there were no shower curtains or shower screens, there were some missing toilet seats and most toilet and bathroom door locks were either missing or broken. One internal bathroom was in a poor decorative state that posed a hygiene risk as surfaces could not be easily cleaned with peeling paint and there were some missing wall tiles. We found a separate internal toilet where the flooring was damaged and could not be effectively cleaned. Following the inspection, the registered manager informed us the provider had a maintenance plan in place to address the issues found on the inspection.

The decorative state of the small laundry was poor, there was no adequate storage and no baskets or bags for either the clean or dirty laundry. Staff were seen carrying dirty laundry in their arms without using personal protective equipment (PPE). We were advised that disposable protective clothing was available however we did not see any items being used. At the time of the inspection one of the laundry machines was broken and a repair had been planned for the day after the inspection, however the soiled and dirty laundry was on the floor in a heap with no clear separation of personal clothing from bedlinen and kitchen textiles. We saw that some duvets that had been washed were piled up in the laundry and not protected from becoming contaminated by the dirty laundry.

There was a storage cupboard where all cleaning substances were held. It is a requirement that substances which could be hazardous to health should be securely stored. The lock on the cupboard was not being used and this meant that people could access the contents of the cupboard which could have posed a risk to them and others.

This was a breach of 15 Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments for people were completed however, most were outdated and many were incomplete, lacking the detail necessary to help safely support and protect people. Risk assessments that related the premises were also outdated, having been undertaken up to three years prior to the inspection.

People were involved in determining their daily activities and routines in the service and people could come and go from the service as they pleased. Where people were at risk from their own actions the staff offered support, and help in a positive way, although this was not consistently provided to any agreed care plan. Staff relied on their long-term knowledge of supporting the same people, many of whom have lived at the service for many years.

Some people at the service had been verbally abused by other people living at Chase Lodge. People responded and let their objections be known to staff however there had been no assessment of the risk or management strategy put in place for occasions when staff intervention was necessary . However, staff were confident that they could keep people safe as necessary. We spoke with the registered manager who confirmed that they would ensure these were put in place and discussed with the local authorities safeguarding team if required.

Incidents and occurrences were not reviewed in any systematic or in-depth way to check for safety issues, patterns of instances or concerns.

People told us that they felt safe living at Chase Lodge. One person said, "Yes, I do actually the fact is I can relax, and I don't worry". Another person said, "It's the people they're alright and I feel safe". People were supported by staff who had received training in how to safeguard people and manage concerns. Staff were clear about how they would raise concerns if they felt people to be at risk. They were confident that should they raise an issue it would be acted on by the registered manager or the provider, and knew of other agencies they could contact should any issue not be responded to. There was evidence that accessible information was provided for people about safety measures or safeguarding.

People told us there were enough staff on duty. One person said, "I think they have got it bang on with the staff." Another person said, "I think there's enough, I am well looked after." People were supported by two care staff on duty plus the registered manager and a domestic cleaner. On five days a week there was also a cook on duty, but on days when no cook was present care staff undertook food preparation and cooking duties. Staff were very busy and whilst people were supported without any excessive delay, the staff had little time or opportunity to interact with people in one to one activities or to support people away from the service. Staff levels were maintained at a minimum of two during the day and night and when the registered manager was not on duty they or the senior care member of staff provided an on-call service to the service. When there were unplanned staff absences the existing staff group covered their duties. At times some of the staff team worked very long hours. The registered manager told us that they were in the process of recruiting additional members of staff and advised that it was planned that staffing levels would be increased during the day so people could be supported in more one to one activities.

There were effective recruitment systems in place. We looked at a sample of staff files. Recruitment procedures included completion of an application form with details of previous experience and any gaps in the work history was accounted for. Two references were provided and checks had been made with the DBS (Disclosure and Barring Service) to check for any criminal convictions. This ensured that people were supported by staff who were suitable to work with people.

Requires Improvement

Is the service effective?

Our findings

People's care and support needs were well known to the long-standing members of staff and they ensured that people felt cared for and respected. Assessments of individual needs had for most people been undertaken at the time of admission into the service and had also relied on and retained assessments from former places of residence to help inform the support that they provided to people.

Staff were not supported to carry out their role through regular supervision and appraisals. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. The registered manager agreed that formal supervisions had not been completed for quite a while however, their door was always open for staff to come and speak to them. Following our inspection, the registered manager demonstrated that they had introduced dedicated formal supervision time, which would be recorded and used to inform further training needs and yearly appraisal.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who lack capacity to do so for themselves. The Act requires that so 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. In the care plans we looked at, we found not everyone had been assessed for their capacity to make decisions. The registered manager could explain verbally why people were able to make decisions for example, regarding their substance use or personal care, which had been questioned by other professionals but there was no evidence to support it. This meant people could be at risk from making decisions that might put them at risk . Following the inspection, the registered manager confirmed that they had completed appropriate mental capacity assessments for everyone living at Chase Lodge who needed them.

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 MCA. The application procedures for this in care services and hospitals are called Deprivation of Liberty Safeguards (DoLS). We checked that the service was working within the principles of the MCA. No one living at Chase Lodge was subject to a DoLS. Staff were aware of the rights of people to self-determine and people exercised their rights accordingly, coming and going as they wished. Whilst people were judged to have capacity, staff provided guidance but did not compromise the right of people to sometimes make unwise decisions. When people had been known to be at risk, if they had not returned to the service after being out, the staff alerted statutory agencies after consultation with the registered manager or senior staff. However, there were no risk assessment documents available to guide staff about action to take.

The service ensured people received support from external health and social care providers as needed and encouraged people to be involved in setting and agreeing meetings with such professionals as was necessary. However, records relating to such arrangements were scant and not always up to date. The registered manager assured us that these would improve with the introduction of the electronic care plans.

People were supported by staff who had the skills to care for them. Newer staff had completed a period of work in the service alongside experienced staff until they were assessed as competent. Staff had undertaken a range of online training and in addition had participated in some group training sessions. Experienced staff had been supported to achieve NVQ qualifications and staff who were new to care work were being supported to undertake training in line with Care Certificate Standards. Staff undertaking this training were supplied with training booklets to be completed as they progressed, with a view to embarking on NVQ training when induction training had been completed. Staff additionally received a monthly training session in the service. Staff had received training in Health and Safety including food hygiene and all staff were due to participate in further Health and Safety training the week after the inspection.

People were happy with the food they received and spoke positively about having plenty of food that they liked to eat. "The food is great and I get a good choice they ask me what I want first thing in the morning and my favourite meal is curry and rice and we get that every other week and yes I do get hungry at night and I eat dark chocolate and [name] does my shopping for me and makes sure I get dark chocolate" and "Food is nice I don't have a favourite food, I like everything". Meal times were structured and the people using the service liked the routine that this provided for them. People had access to drinks whenever they wished and these were consumed anywhere that suited people, some people preferred their drinks in the communal areas and others liked to take their drinks outside or to their own rooms.

Some people living in the service were at risk of not eating enough to maintain a healthy body weight. The staff completed weights charts each month and it was clear that on some months nearly everyone was weighed and on other months only a few people were weighed. Most people in the service did not have a weight related issue, and no reason was provided as to why everyone's weight was at times being recorded. We asked the registered manager about this and they didn't know why but said they would consider this and ensure only those people whose weight needed monitoring would be.

Good

Is the service caring?

Our findings

At our last inspection in May 2016, this key question was rated good. At this inspection it remained good.

People who used the service said staff were kind and caring and treated them well. One person said, "It's alright here." Another person told us "I love being here [name] really helps me" and [Name] (the provider) bought me a bed as I needed a new one".

Staff spoke with us about positive relationships at the service. Comments included; "I like it here, we are a good team and the residents are very nice", "I enjoy my work, the residents are lovely" and "I just love seeing the residents".

Staff treated people with kindness and demonstrated that they knew people well. Interactions between staff and people were relaxed and positive and some people enjoyed being near staff, seeking them out to respond to requests for help or assistance.

People were spoken to in a clear and supportive manner and assistance and encouragement was provided by staff. Our observations demonstrated that staff treated people with great kindness, respect and empathy. Staff also understood and recognised when people needed to work independently and when and how people needed to work through their emotions, distress, challenges and taking responsibility for day to decisions. This included being respectful of decisions that staff might not feel were appropriate however, staff were mindful and respectful of people's rights and choices. This showed that people had choice and control over their lives and that staff responded to them expressing choice in a positive and supportive manner.

People's right to exercise choice was respected and some staff showed a great deal of skill in how they continued to support individual freedom of choice whilst encouraging people to regularly bathe or change clothing. The same level of skill was demonstrated when people wanted access to their own money or goods which they had agreed should be managed by staff in the service and distributed to them regularly. The staff were seen and heard to go through the consequences of the changed decision with the person at the time encouraging them to think through the request in way that was respectful and not undermining of the person rights.

We looked at whether the service complied with the Equality Act 2010 and how the service ensured people were not treated unfairly because of any characteristics that are protected under the legislation. Our observations of care, review of records and discussion with the registered manager, staff, people and visitors demonstrated that discrimination was not a feature of the service.

The service ensured people's care plans and other personal information was kept confidential. People's information was stored securely at the office. Where office staff moved away from their desks we saw computer screens were turned off to maintain information security. A confidentiality policy was in place and gave staff information about keeping people's information confidential.

Requires Improvement

Is the service responsive?

Our findings

People were not always supported to follow their own interests or encouraged to develop new interests. Comments included, "I only do quiz books and I do get bored sometimes" and "I like reading if you tell them that you want to do something then they will help you do it but sometimes it gets boring". Some people had expressed a desire to acquire some daily living skills but there was no evidence that the service had supported people in skill acquisition. This was explored with the registered manager and they confirmed that there had been no attempt to introduce such opportunities for people living in the service. There were no person-centred activities or interests promoted by the registered manager or staff for most people living in the service. An activities programme was on display in the entrance hall and indicated an organised activity for five days each week. We were advised that irrespective of low interest the planned daily activity always went ahead. A weekly bingo session held in the service was reported as being very popular. On the day of our inspection, a music activity took place but only for a short period of time, we were told that activities often relied on the availability of staff.

There was a notice board in the entrance hall that was used and included a list of keyworkers with names of people and a list of the planned weekly activities. The other items on display included an old photocopied picture from a Christmas event in 2016 and three photos of different people who live in the service. Information that was on display was not provided in a readily accessible format; the activity plan was provided in written form only.

This was a breach of 9 Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People told us that the staff cared for them responded to their needs. One person said, ""I just have to ask, and a member of staff helps me." Another said, "I am never rushed, the staff always support me with a smile."

The care and support provided at Chase Lodge met the needs of most people living in the service although people were not always actively involved in making decisions about their needs or how these were to be met. Care planning was undertaken by staff in the service however it often focussed on identifying issues and outcomes, not on how the outcome was to be delivered. Most people had information on file from their previous place of residence or from the initial assessment. When such information was available the subsequent care plan had often made some use of the information recorded. Some care plans contained useful information to help staff know how to support someone with maintaining good mental health and to be aware of indications that their mental health maybe of concern. We had mixed feedback when we asked people about their care plans and whether they knew what was contained in them and if they had participated in their development. One person said, "Oh yes they do that quite regular and I get £60 pounds a week and I save that up and buy clothes with it", however another said, "I don't know" and, "No not seen my care plan". We followed this up with the registered manager, who told that they had recently reintroduced the keyworker system to ensure care plans were reviewed with people and that the new electronic system would alert staff when reviews were needed. We saw keyworker paperwork but this was

completed sporadically. Some of the information contained in the plans was out of date and contradictory. In some instances, there was no indication that the person in receipt of support had agreed the care plan but in other instances people had signed to indicate that they agreed with the plan of care. The registered manager told us that they were introducing electronic case recording to improve the care planning process However, from care plans held on file it was clear that some people had signed to agree that the care plan in place was reflective of their wishes. In other files we found that there was no recorded agreement from the person and no indication or note to explain why the person had not signed the agreed care plan. In other people files and care notes there was no clear rationale or agreement about why the person had wanted staff to administer their medication when other aspects of their daily life indicated that they exercised a great deal of choice and autonomy.

Where people and their families needed to consider end of life care, care plans contained individualised information about people's current end of life wishes and preferences. However, where people did not feel ready to discuss end of life care arrangements, this was not documented. The registered manager told us that they would address this when the care plans were moved to the electronic system.

Information was exchanged daily between incoming staff and those due to finish. When staff had been off duty for any length of time or were not present at handover there was no set method being used to ensure that staff were brought up to date about the care and support needs and things that might have changed. For example, two people had been admitted to hospital from the service over a weekend and one person had received attention from a paramedic after having a fall whilst outside the service. Staff learnt about these occurrences at different times as there was nothing written formally or in their care plans to reflect this. We witnessed the morning handover and found the handover notes did not reflect the verbal handover, so if staff had missed the handover they would not know the most up to date information as the verbal handover was informative and useful. The registered manager advised that they were considering how to improve the handover arrangements and had plans to introduce changes.

The service had a complaints policy and people were aware of how to complain. Comments included, "No never they don't do anything wrong they're always in the right, but if I did I would complain to [name] or [name]" and "When I first came I complained about the food but its ok now"

We saw records of where complaints were made, and the registered manager had responded and acted. The registered manager told us that they regularly spoke with people to check that they were happy with things at Chase Lodge, meaning they could resolve any issues before the need for formal complaints were made.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in May 2016, we found that the registered manager did not have effective systems in place to monitor and improve the quality of the service. At this inspection, we found this was still the case. Although there were some processes in place to monitor the quality and safety of the service these were not comprehensive. For example, although there were cleaning schedules and an infection control audit in place, these did not cover moving and handling equipment or the medicines room. Consequently, it had not been identified prior to our inspection that these areas were not sufficiently clean. The shortfalls found at this inspection had not been identified through the service's monitoring systems.

Audits conducted by the registered manager were not consistent or effective in identifying areas of concern. The provider had conducted two audits of the service but these were not sufficiently regular to monitor the running of the service. The record of one audit visit by the provider included details of conversations with people. A discussion with the registered manager was also recorded. Two members of staff were spoken with and a visual inspection was conducted. No documentation or records were reviewed as part of the audit, no issues were identified and consequently no action plan was developed. This failure to ensure effective audits were undertaken meant shortfalls were not identified prior to our inspection.

We asked to see care file audits. The registered manager told us there were no care file audits in place. This meant there were no effective systems in place which ensured the service could identify and make improvements. Records in the service had not been reviewed. We found records which were inaccurate and did not reflect people's needs or the services on offer.

Systems to ensure care plans were updated because of incidents were not effective. Behaviour records had not been effectively reviewed and learning from these had not been incorporated into care plans. Consequently, two peoples care plans were not accurate or up to date. This failure to ensure accurate and up to date records were kept of people's care and support placed them at risk of receiving inconsistent and potentially unsafe support.

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

We found that the provider did not always demonstrate a comprehensive understanding of Care Quality Commission (CQC) requirements. Records showed that the police had been called to the service on more than one occasion, which had not resulted in a notification being sent to CQC as stipulated by legislation. This impeded CQC from monitoring the safety of people who used the service. The registered manager had sent these in retrospect following the inspection.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We saw that people who used the service had a good relationship with the registered manager. Both staff and people spoke highly of them. One person said, "I think she's very good if you need something explained

she's very good at it and you can make sense of it". Another said, "[Registered manager] she's lovely and she's doing a good job and [name] she's lovely as well".

Staff told us they would whistle blow to external agencies should they have concerns about the care and support provided at Chase Lodge and this was promoted by the provider. This meant whistle blowing concerns would be raised and acted upon appropriately.

People were given the opportunity to feedback about the running of the service by attending residents' meetings. These meetings were held every three to four months and were led by a senior staff member who also took the minutes. However, the registered manager told us that they had not conducted surveys for people, staff or professionals for some time but they intended to do so within the next month.

The registered manager told us team meetings had not taken place for a while. Therefore, the views and opinions of staff was not being captured to help develop the service. However, staff told us they felt well supported and could approach the registered manager at any time for advice and support.

We saw there was partnership working with psychologists, Community Psychiatric Nurses and professionals working in mental health services.

Throughout our inspection the registered manager was responsive to feedback and acted to address areas of concern, ensuring immediate risks were reduced. After our visit they provided us with an action plan based upon the feedback we provided.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and online where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. The provider had displayed their most recent rating in the service and on their website.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Notification weren't sent following incidents involving the Police.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not always supported or encouraged to follow their own interests at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed appropriately or safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

Audits were not in place to monitor the quality of the service provided to people.