HC-One No.1 Limited

Chaseview Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Chaseview Care Home is a residential care home providing personal and nursing care to up to 120 people. The service provides support to older people and people living with dementia. At the time of our inspection there were 103 people using the services. The accommodation was arranged across four separate units. One of the units specialises in providing care to people living with dementia. Most bedrooms have en-suite facilities. There is a large communal lounge, a dining room, and a garden.

People's experience of using this service and what we found
The systems in place to audit the quality of the service were not robust or sufficient to alert the provider of the concerns and issues within the service. Audits had not picked up areas which were identified during the inspection. People were at risk because the provider had not acted to ensure they had sufficient oversight of the service. Records were an area of concern across the service; records were not complete and accurate.

People were not always supported in a way that was safe. Risk assessments contained inaccurate, out of date and contradictory information, especially in relation to food and fluid, risks of falls, and, bladder and bowel assessment. In some cases, risk assessment were missing altogether, for example, in relation to epilepsy and diabetes, and care was not always provided in line with risk assessments.

The service had systems in place to safely store, administer and record the use of medicines. However, these were not always followed. Medicines were not always being given at their prescribed times. Staff were not following correct infection control procedures when administering medicines. Medicines were not always being stored appropriately.

Agency staff were not always being given appropriate training and handover to understand people's care needs. Audit processes were not identifying areas for improvement and where they did, actions were not being taken.

People's care plans contained conflicting and confusing information about their mental capacity. It was not always clear when a person lacked capacity and when a best interest's decision had been made, who had been involved in the decision making process. Covert medication was not recorded in Deprivation of Liberty Safeguards (DoLS).

Care plans did not contain any information to guide staff as to how to support people to manage specific medical conditions, such as diabetes and Parkinson's disease safely.

We were not assured there were enough staff to meet people's needs. We observed call bells were not always answered quickly. We also observed that call bells were muted or switched off without staff attending to people to find out what they wanted or needed. Staff were recruited safely.

Supervisions meetings with staff were inconsistent, staff were not always given opportunities to discuss their progress or discuss issues. Most staff had completed training in the areas the service identified as mandatory, such as safeguarding and moving and handling. However, the service had not identified that staff required training around individual health needs and conditions, such as diabetes or epilepsy.

People were not always treated with dignity and respect. People's cultural needs were not always respected. Most people told us the staff were nice and kind.

Some people told us their personal care needs were not always met. People's care records did not always evidence people had received personal care. Care and support plans for people with long term conditions lacked detail. There were very little activities taking place in the service.

There was a lack of provider and managerial oversight of the service. There was a failure by the provider to ensure robust governance arrangements were in place to monitor the safety and quality of the service. Shortfalls across the service such as poor risk management, lack of oversight of medicines and limited oversight of people mental capacity had not been identified prior to our inspection. The provider had failed to sustain and make improvements to the service following previous inspections.

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

Rating at last inspection and update
The last rating for this service was requires improvement, published 15 October 2019 and there were no breaches. At this inspection not enough improvement had been made, the provider was in breach of regulations 18 for the third time and regulation 17 for the second time. Further breaches of regulations have been identified in this inspection.

Why we inspected
The inspection was prompted in part due to concerns received about the staffing levels, infection control, the environment and the overall safety of the service. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We have identified breaches in relation to safe care and treatment, good governance, staffing, need for consent, person-centred care, privacy and dignity, premises and equipment, and, meeting nutritional and hydration needs.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is Inadequate and the service is therefore remains in special measures. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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.

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 safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not responsive.

Details are in our responsive findings below.

Inadequate

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Chaseview Care Home

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was undertaken by two inspectors, a bank inspector, two medicines inspectors, a nurse specialist advisor, and, two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Chaseview 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.

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

At the time of our inspection there was not a registered manager in post. There was a manager who was applying for this role. We were supported by senior members of staff and an area director, who was a representative of the provider and was managing the service.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We reviewed a range of records. This included 16 people's care plans and risk assessments. We reviewed 11 people's medicines administration records in detail. We also looked at staff files, maintenance records, Deprivation of Liberty Safeguards authorisations records, and, accidents and incidents records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

We spoke with 17 members of staff including the manager, area director, quality assurance lead, clinical lead, six healthcare assistants, three registered nurses, two chefs, one agency staff, and, one maintenance person. We also spoke with 30 people living at the service and made observations within the communal areas. We also spoke with two health professionals.

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.

We continued to seek clarification from the provider to validate evidence found. We requested additional evidence to be sent to us after our inspection. We looked at training data and quality assurance records. We spoke with 20 relatives by telephone about their experience of the care provided.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Robust risk assessments were not in place to ensure people received safe care.
- People were not being appropriately protected against risks and action had not been taken to prevent the potential for harm. Risks to people had been identified and a risk assessment put in place, however, we saw there was not always sufficient guidance in place to manage risks.
- Two people whose files we reviewed were identified as being at risk of having epilepsy. There was no guidance in place regarding how to mitigate the risks associated with their medical condition. One person's risk assessment for epilepsy said, 'To follow laid down rules'. We asked the nurse to provide more information about the rules. The nurse was unable to provide any answer to this.
- Another two people had dementia. There was no risk assessment or capacity assessment in place to address this. Another person had diabetes, there was no risk assessment or guidance in place regarding how to mitigate the risks associated with their medical conditions.
- In another person's care plan, we looked at their bed rail risk assessment which mentioned, 'Crash mat should be put next to their bed as when they fall out from bed, and, bedrail is not in use'. In other section of their care plan, it was mentioned this person was using a bed rail, but no information was recorded regarding a crash mat. The care plan contained conflicting and confusing information about their bed rail assessment. This meant this person was at risk of a potential for a serious incident.
- We also reviewed one person's care plan, which stated that during mealtimes this person needed encouraging after every bite, otherwise they would not swallow and could be at risk of choking. During our lunch observation we noticed staff was not engaging with this person, as they were busy helping with lunch preparation. Staff failed to provide support in line with their assessed needs.
- We looked at three people's care plans who were at risk of malnutrition. Risk assessments did not indicate if staff were to monitor, or, record the amounts of food to be eaten. Two care plans confirmed people were at risk of dehydration. Risk assessment did not indicate if staff were to monitor, or, record how much fluid a person took each day. This meant it was not possible to monitor whether they were taking enough fluids or food to keep people safe.
- Some people in the home could display behaviour that could challenge. This included verbal, non-verbal or physical behaviour towards staff or other people. However, risk assessments did not guide staff on how to de-escalate the behaviour or situation and encourage more positive behaviour.
- There had been a significant number of unwitnessed falls in the twelve months prior to our inspection. Whilst falls were reported to the local authority, accident records were not reviewed, and not enough action was taken to minimise the risk of falls. We also did not see any evidence of this being shared with staff, or, what actions had been taken to mitigate future risks. For example, there was no clear guidance for staff about immediate actions they should take in response to distressed reactions from people. This meant there was no learning from incidents, or analysis to identify themes and trends and actions taken to prevent

reoccurrence.
● These failures evidenced a lack of learning from events or action taken to improve safety, placing people at risk of harm.

The failure to assess, record and mitigate risks to people's health and safety was a breach of regulation. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment)

● Checks were carried out on the premises. These included checks related to fire safety, gas and electrical installations. Please refer to the Effective section of this report for more details.
● Staff had completed Personal Emergency Evacuation Plans (PEEPs) for people which included consideration of specific risks. The area director spoke of their plans should they need to evacuate people in the event of an emergency. People's records included clear instruction on how to use evacuation equipment. This provided assurance that risks to people from fire were being assessed and managed effectively.
● People and their relatives told us they felt safe and could talk to staff. One person told us, "Yes, I do feel safe here because staff are around." Another person told us, "I have been here two years, yes, I do feel safe here because people are around."

Staffing and recruitment
● The service did not have enough staff to meet peoples assessed needs. Staff told us there were not enough staff to provide people with appropriate personal care, such as showers, accessing the toilet on a regular basis, and people had to wait for staff to provide care.
● Observations of mealtimes confirmed there were not enough staff to ensure people were adequately supported to eat. People were left to eat independently, had little interaction with staff and therefore did not receive the encouragement or practical help they needed to eat, either independently or with support.
● Staff consistently told us there was not enough staff. One staff member said, "Yes, we do need more staff and some of the residents do require two people to support them [people]." Another staff told us, "It can be challenging to support them [people] in the morning." One relative also shared their concerns, " There is never enough staff on duty, so care depends who is on that day."
● At the last inspection, we found call bells in some units were not responded to within an adequate time. During this inspection, the area director told us staff should respond to call bells within five minutes, however; when we tested this, we found response times were 20 minutes. We then asked a nurse why no one responded to the call, the nurse was unable to provide an answer.
● People's families gave feedback regarding staffing levels. One family member told us, "They are always short of staff there." Another relative said, "Although we asked for a shower [person] staff will say they are short on staff, so they [person] can't have a shower."
● This meant that people using the service may be at risk of harm through the lack of suitably qualified, skilled and experienced staff being available on duty.

The provider had not ensured that sufficient numbers of suitable, experienced staff were deployed to meet people's assessed needs. There was not a systematic approach to determine the number of staff needed and to meet the needs of people using the service and keep them safe at all times. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment practices were robust. The provider completed checks on prospective employees to ensure they were safe to work with people. These checks included seeking references, checking staff criminal record

and checking their identity.

Using medicines safely

● Medicines were not managed safely. People who were prescribed time-sensitive medicines for the treatment of Parkinson's disease did not always get these at the correct times. Failure to administer these medicines as prescribed could result in the person experiencing unwanted symptoms of the disease and a deterioration in their condition.

● Medicines were not always stored at the correct temperature. Temperature monitoring was conducted daily but staff did not actively manage changes throughout the day where the ambient room temperature could exceed the maximum 25^{0}C. On the day of the inspection one unit was registering as 28.5^{0}C. We raised this with staff however, they did not take action to reduce the temperature or ensure medicines were suitable for use. Medicines not being stored within the licensed recommended temperatures might have an adverse effect on the medicines and their effectiveness. When we spoke to staff on the day about our concerns staff did not seem to understand them or their responsibilities. Staff took no action on being told the current temperature exceeded the recommended maximum other than saying maintenance would be contacted and the air-con unit had been condemned. We are not assured that medicines are being stored safely at the correct temperatures.

● Records for controlled drugs (medicines with additional storage and recording requirements) were not always completed accurately. Access to the Controlled Drugs (CD) cabinet was not always secure. We found in one of the units that the methadone (Schedule 2 Controlled drug for the treatment of opioid addiction) bottles were being recorded as 40ml administered for a person but when we looked at the bottles these were 39ml bottles. We're not assured staff on the unit were recording accurately what they were administering to the person.

● Where non-nursing staff administered medicines there was not always the documentation or training in place for this to be done safely. PRN (when required) protocols were missing on the units where non-nursing staff would make the decision about when and how to administer these medicines. Staff also did not understand the difference between medicinal creams and hydrating creams.

● The service was not calibrating its blood glucose diagnostic equipment for diabetic care management. People's diabetic care plans, where they were in place, contained some information about how to manage hypoglycaemia, but were not individualised. The service had taken a blanket approach to blood glucose testing. They were not recording this accurately or following national guidance on how often these were needed.

● There were no individual fire risk assessments in place for people prescribed paraffin-based skin products. This meant people were at risk of a potential for a serious incident.

We found no evidence that people had been harmed. However, medicines were not always managed in a safe way. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider's infection prevention and control policy was up to date.
● Infection control processes were not being followed in the service. Medicine storage areas were not kept clean and hygienic. We were not assured staff were following good infection control processes when administering medicines.

Systems and processes to safeguard people from the risk of abuse
● Systems were in place to safeguard people from the risk of abuse. Policies were in place which made clear the provider had a responsibility to report any allegations of abuse to the local authority and the Care Quality Commission (CQC). Records showed that this was done.
● Staff were aware of their responsibility to raise safeguarding concerns to the manager.
● Staff had undertaken training about safeguarding and understood their responsibilities about it. One staff member said, "I would stop the incident straightaway. Speak to the person and reassure them. I will then speak to my manager, and then write up an incident report. If nothing happens, I will contact the head office, or call the police."

Visiting in care homes
● People's relatives told us visiting was easy, and they could arrive whenever. Visitors were required to have their temperature taken and sign in the visitors' book. Visiting was facilitated in people's bedrooms.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question requires improvement. The rating for this key question has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were not always assessed in line with guidance. There was a lack of detail about how to support people with their personal care. People's needs were not fully assessed prior to them using the service. These included obtaining information from people and their relatives about their needs and preferences and how they would like to be supported.
- Care plans did not detail people's preferences for when they liked to have a shower or a bath. No information was recorded of what type of clothing or jewellery people would like to wear. The lack of detail about the person's routine in the care plan meant there was a risk that if a new care worker started providing care, they may not have all the information to meet the person's needs and wishes.
- Records did not provide relevant information for staff. For example, risk assessments had not offered guidance to support a person when they experienced distress. Staff were observed offering support in a respectful manner. However, the lack of guidance increased the risk of people not receiving consistent support when they were experiencing distress. Staff told us they did not have any formal method to record what led up to episodes of distress, what was happening for the person or what supported them to manage this. One staff told us, "We don't have this information in front of us, we get hit or get bitten by resident [people] there is no record-keeping on how to prevent injuries."
- The provider failed to ensure they had an effective system to support people to manage emotional distress. Consideration had not been given to the function behaviours that may challenge others or self-injury may have for people, and the provider had not sought or carried out functional behavioural assessments.

The provider did not always carry out appropriate assessments to ensure the service could meet people's needs. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Staff undertook regular training in a variety of subjects, including moving and positioning people, equality and diversity and fire safety. However, many staff had not undertaken training in key subjects relevant to their roles and the people they supported.
- For example, two people using the service had diabetes and two people had epilepsy. However, most of the care staff with responsibility for supporting those people with needs related to diabetes and epilepsy had not undertaken training in these areas.
- Staff received medicines training which was a mix of online and face to face. However, face to face

competency assessments were only completed every three years as per the company policy. National guidance suggests this should be completed annually to ensure that staff are following best practice.
● The service used agency staff to cover care and nursing duties. One agency staff was called in at short notice to work on a unit having never worked there before. They were given no induction, no handover about the people's current nursing needs on the unit and was tasked with administering medicines.
● Staff gave feedback about their experience of supervision and support. One staff said, "I have had two supervisions and one appraisal in the last year." Another staff told us, "I have not had any supervision meeting." Nurses were unclear about supervision arrangements, one nurse said, "Supervisions are done verbally, and we don't write this down."
● We reviewed five staff supervision meeting records. However, all supervision meeting records were duplicated, and did not record any individual concerns, goals or targets. There were no formal competency checks in place to ensure staff were competent in all aspects of their role.
● Records did not demonstrate staff were always receiving effective support and supervision in line with the provider's policy.
● The above issues meant that we could not be assured that staff received the appropriate support and supervision from the provider to enable them to carry out the duties they were employed to perform.

The provider did not ensure that staff received the appropriate training, support, supervision and appraisal as necessary to enable them to carry out their duties. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider told us training will be provided including face to face and practical training for all nursing staff. This includes epilepsy and diabetes training.

Supporting people to eat and drink enough to maintain a balanced diet
● People were not supported to have enough to eat and drink and at the times they wanted. There was a lack of information in people's care plans about their nutritional needs, preferences and support needed to maintain a balanced diet. Care plans did not record people's preferences on food and drink.
● One person's care plan mentioned the person needed to drink 2 litres of fluid per day to avoid constipation. There was no information about whether they preferred juice, water, tea or coffee. No information was recorded of how much this person drank. This could lead to dehydration or skin tear.
● Each person had been assessed by the provider's internal Speech and Language Therapists (SALT) to identify a risk of choking or specialist dietary needs. However, we looked at one care plan around diet and fluid which mentioned this person was on soft and bite sized diet. In other section of their care plan the description of diet said they were on normal food and fluid. Their day to day eating and drinking care plan then said, 'Level 5 food minced and moist as recommended by SALT'. The care plan contained conflicting and confusing information about their food and fluid plan.
● We observed the lunchtime service. The lunchtime services was rushed and staff paid little attention to people to check if they were satisfied with their meal and if they wanted anything else. Condiments such as salt and pepper were not on the tables. After the meal, staff did not provide any wipes or tissue for people to clean their hands or mouth.
● We also observed four people were hunching towards their food as their table setting was not set correctly, which was very difficult for people to reach. This could lead to a potential risk of choking.
● We received feedback on the meals provided. A person commented, "No, the food is not good here, sometimes it's not cooked properly." Another person said, "The food is not good here, hot and cold some days, and, you don't always get what you order and staff say just eat."
● Staff were aware of people's specific dietary needs to manage their medical conditions, allergies, cultural and religious needs.

We found no evidence that people had been harmed. However, records showed that people might not have been provided with suitable food and drink. This was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Records of people's care and treatment in the home did not confirm how their consent to care was obtained and in accordance with the MCA.□
● Where people were on covert administration of medicines, staff viewed this as a last resort and always offered a person their medicines overtly in the first instance. However, DOLs in place did not cover the use of covert administration and we did not find a formal best interest decision meeting having been conducted for people prior to the decision to go ahead with this restrictive practice. Review of current covert administration was only taking place annually for the one person we reviewed. Current best practice says this should be every three to six months.
● People in the home had varying levels of capacity according to their initial assessments. For example, some people had dementia. However, it was not clear how decisions made about their care were formed and who they were made in consultation with. Care plans did not confirm if people were able to understand what their care needs were and whether they had agreed to being supported with them.
● Where decisions were made in their best interest by professionals or the person's representatives, such as relatives, there were no records of this for all the care plans we looked at. There was no evidence the care plans had been agreed and signed by either the person or their representatives. If people had provided verbal consent because they were unable to sign their care plan, this was not documented.
● For example, we saw four people with bed rail consent form. The documents were not signed by the person, or, by families or relatives.
● We fed this back to the area quality director, who informed that they were aware of the issues as it was identified during audits and were addressing this.

Failure to take into account people's capacity, ability to consent and ensure decisions were made by those who have legal authority to do so is a breach of Regulation 11 (need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff received training on the Mental Capacity Act which covered obtaining people's consent prior to delivering any care and the principles of the MCA. One staff member said, "Yes, we have to get consent and

permission before we do any personal care."

Adapting service, design, decoration to meet people's needs
● In general clinic rooms were unclean. We saw unsecured large bottles of oxygen, rusty Stanley knife blades and bolts on the counter on one of the units as well as another filthy air-conditioning unit. During our observation we also found both sluice and storage rooms were always unlocked. This meant people were at risk of a potential for a very serious incident.
● Some doors around the service had signs but they weren't very clear as the images were too small to see. Food menus and activities timetables were displayed in a small written text, despite there being some people living there who can't read.
● People's room doors were not personalised. During our inspection we did not know which room residents resided in as there were plain doors.
● There were four units and each unit had a dining area and communal area. There was a garden that was maintained if people wanted to go outside.

We found no evidence that people had been harmed. However, we found some instances of poor maintenance of the premises. This placed people at risk of harm. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider told us they had taken action to clean the clinic rooms.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People were not supported to live healthier lives.
● Interaction with health care professionals was recorded in care plans to assist staff to support people appropriately. Healthcare professionals, such as GPs, occupational therapist and dieticians were all engaged in supporting people to have their health needs met by the service. However, we identified the staff were not then implementing guidance, or equipment into their practice to maximise people's levels of independence and safety.
● During the course of our inspection we noted visiting social workers and an occupational therapist attended to carry out reviews of people and then discuss with the unit manager about people's medical needs. One occupational therapist said, "This [person] had been in this home for over two weeks now, and, they have not provided [person] with an air mattress, air cushion and float heels." This meant this person were at risk of a potential for a serious injury.
● People attended appointments to receive treatment or check-ups. Relatives told us they were contacted by staff if people were not well or there were changes to their health.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- People were not always treated with dignity. While observing the home and the environment, we saw people's doors wide open. We saw a few staff members going to people's rooms without knocking or asking their permission to enter.
- We saw one staff walked into one person's room who was only wearing a pad. Staff did not acknowledge this person, nor did they cover their lower body. Staff then removed the pendant alarm away from the person, saying they would press pendant alarm for no reason. This left this person at risk as they were not able to call for assistance. After the inspection we raised this concern with the provider. The provider will arrange a staff meeting and arrange one to one meeting with this particular staff.
- Due to lack of enough staff, care was delivered in a task-based way rather than considering people's needs and wants.
- Some staff did not engage or smile at people whilst serving meals. A person who was sat alone in their bedroom was provided with assistance to eat their lunch. However, the staff member supporting them failed to engage in conversation with them.
- During our two-day inspection, we observed an instance of no engagement or interaction between staff and people. For example, we saw two staff sitting around the dining table, five people were sitting and watching TV. These practices did not ensure people were cared for and supported.
- Other concerns we found included how some care plans were written. One person was described as having limited capacity but liked talking. Their care plan included the phrase, "[Person] is described pleasantly confused and is being nursed in a bay near the nurse station." This lacked respect for the person and their needs and could encourage staff to be dismissive of their views.
- People's families gave mixed feedback regarding the care they received. One relative said, "Yes, they [person] do have a good wash every morning, and staff are kind to [person]. They let [person] wash their hands and face but they [staff] will wash everything else." However, another relative said, "When I went one Saturday around 11.15am I found [person] in bed with a vest on and a nappy. When I asked the staff why [person] was in bed, the staff member said we are getting [person] up."
- Care plans did not always contain information relevant to the person and were not individualised to reflect people's needs. A positive person-centred culture was not promoted which took account of people' views and preferences and promoted good outcomes for them. Staff told us they understood people. A staff member said, "We take our time to understand residents and their needs. We observe what they like to do and eat."

● Whilst people's care plans listed the things they liked to do and they enjoyed, we found that these were not always part of the support they received. For example, a person liked gardening, however, they were not supported to do gardening.
● People's needs in relation to equality and diversity were not always covered in their care plans. Protected characteristics such as race, religion and sexual orientation were only briefly mentioned. For example, if a person identified as being of a particular faith or religion, there was no further information about how they could be supported to practice or attend places of worship.

The provider failed to ensure people were treated with dignity and respect. Staff failed to ensure people's privacy was maintained. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We discussed these observations with the manager and the area director who told us they would remind staff of their responsibilities to ensure they treated people with respect and promoted their dignity.

• Staff ensured people's confidentiality was maintained. Personal information was stored securely and only accessed by authorised staff. Information was protected in line with General Data Protection Regulations (GDPR).
• Staff ensured they explained what they were doing and sought people's consent when offering support. One staff member said, "I will knock on their door before I enter their room. I will introduce myself and ask them [people] how they are doing. I will seek their [people] permission before I start on personal care. I will close the doors to main their privacy and dignity. Once personal care is completed." However, during our observation we saw a few members of staff going to people's room without knocking.
• Staff were trained in understanding equality, diversity and inclusion. Staff were aware of how to not discriminate against people. Staff told us they respected people's beliefs and protected characteristics, such as their disabilities. A staff member said, "We have known them [people] for a long time. I treat everyone equally and do not discriminate because we are here to care for them."

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Care plans were not always personalised. Care plans were in place for people. However, we found they were not always personalised to include people's preferences, wishes, needs in key areas such as life history, mental capacity, personal care, nutrition and hydration. This meant that staff reading the care records would not have the guidance or instructions to provide people with person-centred care. For example, agency staff were unaware of which people they supported had diabetes or epilepsy.
- Important relevant and specific information to help staff deliver personalised and responsive support to people and promote wellbeing was lacking. There was no detailed and relevant information to tell staff why an individual might become agitated or anxious, any triggers that might heighten their anxiety or ideas about how to distract or engage positively with them.
- There were no details in peoples' care plans that reflected what time they liked to get up. Staff told us that there were some routines in place that appeared to suit the staff, rather than people. For example, one person was assisted to get up at 6am every day because, "It's always been that way, that's how it's done".
- We looked at two care plans for people who had diabetes. Care plans mentioned people's support needs with food and drink. However, care plans did not detail their food and drink preferences.
- Another person's care plan mentioned staff needed to support with equipment to manage their health condition, however, there was no guidance for staff to ensure this was managed safely.
- Records of care were poorly maintained and did not demonstrate people received care in a way that met their needs and preferences.
- Care plans lacked information about people's interests, social activities and stimulation.
- There was little in the way of activities in the home at the time of our inspection. We observed people sitting down while the television was on for most of the day.
- People were not supported to engage in activities which were socially or culturally relevant to them. The service employed seven members of staff to coordinate activities for the 102 people living in the service. Although, they tried to engage with multiple people at the same time in activities, there was not enough time or staff to provide meaningful interactions.

We found no evidence that people had been harmed. However, we found arrangements were not in place to ensure that people received care that was person-centred. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We discussed our findings with the management team and reiterated the importance of having recorded information about the needs of people, as it would also help new staff get to know them.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People did not receive information in a format they could understand. For example, activities timetables and food menus were being displayed in a written format, there were no posters or signage being displayed.

● Door signage was not clear and visible for people to understand. This meant the systems were not in place to ensure everyone had the opportunity to have a say about their care preferences due to the lack of communication systems in place. Easy read care plans were not available for people.

● Care plans included information about people's methods of communication and/or preferred language. For example, one person was hard of hearing, the provider asked care worker to speak with them in simple sentences loudly and clearly.

We recommend that the provider put systems in place to ensure the Accessible Information Standard is met.

Improving care quality in response to complaints or concerns

● Complaints and concerns were managed by the service. A complaints policy and procedure were in place. The provider reviewed all complaints to identify ongoing concerns and put actions in place to resolve these.

● Relatives told us they knew how to raise a complaint and felt confident any concerns would be listened to and acted upon by the management team. One relative said, " I raised a concern about the care from my [person], and they [provider] managed to follow it up."

End of life care and support

● There were systems in place to discuss, record and support people's palliative care and end of life care needs. People could choose if they wished to discuss their end of life care wishes with support from their relatives. Their individual preferences were recorded in their care plans. These included advance care plans, which contained information about their preferences for their funeral arrangements.

● Where appropriate, people also had Do Not Attempt Cardiopulmonary Resuscitation forms that they signed and agreed in consultation with their relatives and health professionals.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The systems in place to audit the quality of the service were not robust or sufficient to alert the provider of concerns and issues within the service. Audits had not picked up significant shortfalls in practices in relation to risk assessment, medicines management, staff deployment, meeting people's health needs, training, capacity and consent, dignity and respect, care planning, and record keeping.
- People were at risk of harm because the provider had not acted to ensure they had enough oversight of the service. There had been a lack of provider and management oversight at the service which had caused issues with safe staffing levels, monitoring of practice and day to day management. We discussed this with the provider.
- Although audits of the service had been carried out, they were ineffective as they had not identified and managed risks to ensure people received care and treatment in a safe way. This meant the compromised quality and safety issues found on inspection had not been identified or responded to appropriately and without delay.
- The provider completed a support visit report which was led by their Quality Assurance Lead. The report was completed in June 2022 and had identified many of the issues we found with care plans, risk assessments, health information and person-centred care. These issues had not been addressed despite being well known by the provider.
- The provider had not kept appropriate oversight of staff training, supervision and staffing levels and deployment; we found this impacted on the quality of care people received.
- Staff told us they did not feel supported, and felt morale was "very low". One staff member told us, "I love working here, but we always feel rushed and you dread coming to work because you don't know what it's going to be like."
- Staff were informed through staff meetings of concerns found from their internal audit, such as personal care and infection control. However, these were not discussed in relation to how to improve and what role staff should take in making improvements. Also, there was no discussion about people's falls or how to prevent falls.
- The quality of staff supervision and observation records were poor. There was little evidence of what had been discussed or observed and there were missed opportunities in supervision to support development of staff knowledge.

● Staff were not given the opportunity to be involved in proposing new ways of working or suggesting improvement. One staff member said, "We don't get told anything, we just get a hand over."
● Where the service was working with other professionals, we identified the staff were not then implementing guidance, or equipment into their practice to maximise people's levels of independence and safety.
● We saw that some feedback had been sought from people living at Chaseview Care Home, however it was not clear if any action had been taken in response to the feedback received.
● During our inspection, the provider confirmed they accepted that their quality assurance systems had not operated as well as they should. The local authority had visited the service shortly before our inspection and found areas of concern.

The above evidence shows that the provider did not have effective systems to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We identified concerns in relation to the oversight, operation and management of the service. The registered manager had recently left their post, and there was a new manager at the time of the inspection, who had only been in post for a very short time frame. People told us the new manager was approachable, more open and supportive.
● Most staff we spoke with spoke highly of the new manager. One staff said, "[Manager] is new here, he is welcoming and has new ideas for this home." Another staff member said, "We know the challenges here, [manager] wants to work with us to improve the home."
● During our inspection we provided feedback to senior management team about issues of concern we found. The provider accepted that some things had gone wrong. Over the course of the inspection the provider took positive action to make improvement. For example, developing care plans and risk assessments that were missing around diabetes and epilepsy.
● Relatives received information from Chaseview Care Home if the person was attending any health appointments and or if there were any changes to their health.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider was aware of when the CQC should be made aware of events and the responsibilities of being a manager. They have reported events and accidents and incidents to CQC when these had occurred and as required by law. Certificates of registration and the ratings were on display in the communal areas, as well as their employer's liability insurance certificate.
● The provider and the manager understood their responsibilities under the duty of candour. The provider and the manager had been open and transparent with people when incidents occurred where the duty of candour applied.