Chasewood Care Limited

Chasewood

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

Summary of findings

Overall summary

The inspection took place on 29 May and 18 June 2018 and was unannounced. We made a second visit on 18 June 2018 to check that the provider had taken the actions they said they would take, to minimise risks related to the premises. At our previous inspection the service was rated Good overall but rated Requires Improvement in well-led. At this inspection, we found the provider had not made the required improvements in well-led, the safety and quality of the service had deteriorated and we found breaches of the Regulations. The rating has changed to Inadequate.

Chasewood 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 home accommodates up to 26 people, who may live with dementia, in one adapted building.

There was not a registered manager in post. The registered manager had left the service in December 2016. 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. The new manager had not registered with us and they left the service in May 2018.

We found systemic and widespread failings in the management, monitoring and oversight of the service, which meant people did not always receive safe care. There was not an effective system to identify and manage risks to people's safety through planning and delivering care or in how the premises were used. The provider's fire risk management arrangements did not include a register of everyone who lived at the home and their oversight of fire prevention and control measures was inadequate.

The provider had failed to take the actions they said they would take to minimise risks to people's safety related to the premises. The provider had failed to identify new risks to people's safety related to the premises and failed to respond to staff's repeated requests for repair or replacement of the premises and equipment.

The provider's systems and processes did not ensure people were protected from the risks associated with medicines management, infection prevention and control and food safety and here were not always enough staff on duty to support people safely.

The provider and staff did not understand the principles of the Mental Capacity Act 2005, and one person was unlawfully deprived of their liberty. People were not always supported to receive the healthcare support they needed to minimise risks to their health.

The provider's oversight, monitoring and auditing of the service failed to identifying risks, trends or patterns that would have enabled to them make changes to the quality of the service. The provider did not challenge

staff's practice when they were less than caring or responsive to people's health, social and emotional needs. The provider's failure to ensure people were treated with respect and dignity, did not give the right leadership or support to enable staff to treat people as valued individuals. Care plans contained insufficient detail about people's personal histories and interests to support staff to deliver person centred care and staff did not deliver a person-centred service.

People had limited opportunities to engage in meaningful activities that they enjoyed. The provider did not operate an effective complaints handling system that would have enabled them to identify trends or areas of risk that they could have addressed to improve people's experience of the service.

People's care plans were not updated accurately when their needs changed, to give staff the guidance they needed to support people safely and minimise their personal risks. Other records related to people's care, support and treatment were incomplete or not up to date. There was not an effective or auditable system of sharing important information about people's needs, or any changes to their abilities and the support they needed.

People's and relatives' views of the service were not sought, heard or responded to. Staff experienced a lack of communication, inconsistent direction and guidance and were not supported to be instrumental in making the required improvements.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures. This is the second time the service has been in special measures since November 2015. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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?

Inadequate

The service was not safe.

The provider had failed to make the improvements in the safety of the premises that they said they would make. People's individual risks were not minimised, due to staff's inaction and out-of-date care plans that lacked sufficient detail. The provider's systems to minimise risks to people's safety in relation to the premises, medicines management and infection prevention and control were inadequate. There were not always enough staff to support people safely.

Is the service effective?

Inadequate

The service is not effective.

The provider and staff did not understand their obligations under the Mental Capacity Act and had unlawfully deprived a person of their liberty. Improvements were required in the oversight of staff's practice, to ensure people were supported effectively, particularly those who live with dementia. Improvements were required in supporting people to eat and drink enough to maintain a healthy weight and to maintain an interest in eating. Improvements were needed to meet people's individual needs in the use, adaptation and decoration of the premises.

Is the service caring?

Requires Improvement

The service is not caring.

Improvements were required to ensure people felt cared for. Improvements were required in supporting people to maintain their dignity and promote their independence. Improvements were required in obtaining, sharing and using information about people's lives, preferences and motivations, to make sure they received the emotional support they needed.

Is the service responsive?

Requires Improvement

The service is not responsive.

Improvements were required to ensure people's care plans were

effectively reviewed and updated to reflect people's changing needs. Improvements were required in staff's understanding of people who lived with dementia. Improvements were required in how people who lived with dementia were supported to engage with their surroundings and take part in meaningful occupations. Improvements were required in how complaints were handled and responded to.

Is the service well-led?

Inadequate

The service is not well-led.

Improvements were required in the quality of the service. Improvements were required in the provider's systems and processes for the safety and governance of the service. Improvements were required in the leadership and management of the service. Improvements were required in obtaining and listening to feedback from people, relatives and staff to enable the provider to make improvements that met people's expectations. Improvements were required in the provider's willingness and ability to learn from their experience and make improvements to the service and to people's lives.

Chasewood

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part because we had concerns about the provider's governance systems and leadership at their other home when we inspected it in April 2018. We were also aware that the local authority had imposed a placement stop at both services, due to their concerns about how both homes were managed.

The inspection visit was undertaken by two inspectors on 29 May 2018 and was unannounced. One inspector returned unannounced on 18 June 2018, to check the provider had taken the actions they said they would take, to minimise risks related to the premises. We reviewed the information we held about the service. We looked at information received from relatives, the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events, which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services, which are paid for by the local authority. We did not ask the provider to send us a provider information return, because the inspection was undertaken in response to information we already knew from other agencies and our knowledge of the provider's other service.

We spoke with two people and a relative about what it was like to live at the home. We spoke with the deputy manager, three care staff and the provider about what it was like to work at the home.

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

We reviewed three people's care plans and daily records, the medicines administration records for two

people and other aspects of medicines management to see how care and support were planned and delivered. We checked whether staff were trained to deliver care and support appropriate to each person's needs. We reviewed elements of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Inadequate

Is the service safe?

Our findings

At our last inspection we rated this service Good in safe. Since that inspection there had been changes in how the service was managed. At this inspection, we found the provider had not taken all reasonable measures to minimise risks to people's safety. We have rated the service Inadequate in safe.

Systems and processes to minimise risks to people's safety were inadequate. Risks related to the premises that we had identified at our inspection in February 2017, had not been addressed. During our previous inspection the provider had fixed some broken call bells and had made a partial repair to a broken window sill, which they assured us they would complete. However they had failed to complete that repair, and had failed to take other actions they said they would take, to minimise risks to people's safety related to the premises. They had not implemented the 'management walk-around checklist' to include day to day maintenance checks and there was a deterioration, not improvement in the safety of the premises.

At our previous inspection, the provider had told us they would change the bedroom window restrictors in line with the Health and Safety Executive (HSE) guidance, to ensure people could not get in or out of the windows unobserved. At this inspection, we found only one window was restricted in line with HSE guidance. Some bedroom windows had restrictive chains, but some were broken and did not restrict the window openings at all. In two bedrooms the windows were ill fitting and there were large gaps between the window and the frame. Staff had put paper masking tape over the gaps and it was clear this 'temporary' solution had been in place for some time as the tape was peeling off. In two other bedrooms the window catches, stays and restrictor chains were broken, which meant the windows did not open or close securely.

On the half landing between the ground and first floor, there were two large windows without restrictors which were low level and opened out onto a flat roof. There was a risk that people who lived with dementia and liked to explore their surroundings, could step out onto the flat roof and fall off. The provider had not identified this risk and had failed to keep people safe from risks related to the premises. In June 2018, we wrote to the provider requesting their assurance they had taken immediate action to mitigate the risks to people's safety related to the premises. On 14 June 2018, the provider assured us in writing that they had made the necessary window repairs. However, at our second inspection visit on18 June 2018, we found they had not taken the action they said they had taken. We imposed a condition on the provider's registration that they must take immediate action to mitigate risks related to people's safe use of the premises.

The cupboard that houses the lift operating machinery was not locked, even though it had a large sign on it that said, "Keep locked", for people's safety. This was in a communal area where people had unrestricted access to walk about unobserved and could have come to harm.

Risks to service users' safety in the event of a fire or an urgent evacuation of the building, had not been mitigated and there were risks related to fire safety that the provider had not identified. Despite the provider's written assurances of 14 June, on 18 June 2018, the fire 'grab bag' still did not contain a register of all the people who lived at the home to enable a safe and effective evacuation in an emergency. Staff training records did not identify whether staff had received any training in fire drills. The recently appointed

deputy manager told us they had tested the fire alarm twice in the last two weeks, but they had not recorded the test. They told us they had identified one fire safety door did not close and seal effectively, and had reported this to the provider verbally. There was not a written record of their fire safety checks or of the risks they had identified or of the actions needed, with a planned date for completion. The provider had not given them a framework or checklist of fire safety and prevention measures, to make sure all risks were identified and mitigated effectively. We have shared our concerns about fire safety with the local fire prevention and control service. We told the provider to take immediate action to mitigate risks related to fire prevention and fire safety.

The provider's system for responding to staff's concerns about the safe use of the premises was inadequate. Risks to people's safety were not adequately assessed or mitigated to ensure they stayed safe and their freedom was respected. At our last inspection, staff told us the book, to record all identified maintenance issues, had 'dropped out of use'. At this inspection, we found the provider and staff were still not able to show us a list of all the maintenance requests and there were still risks related to the premises, with no planned completion date. The lack of a written record resulted in a failure of management oversight or control over the condition of the building and equipment and risks related to the premises were not mitigated.

One person's bedroom had a large patio door leading onto the garden, but the handle was broken, which stopped the lock from operating correctly. The door was permanently unlocked, which meant anyone could exit or enter the building unobserved and was a risk to people's safety. The provider told us they did not know about this risk. The hand dryers in the communal toilets and bathrooms were either not working, or switched off. The dishwasher was broken during our previous inspection and was still not repaired or replaced at the time of this inspection visit. Staff had requested replacement fly screens and a replacement electric fly killer in February and again in March 2018. These items had been obtained, but were still in their packaging on the kitchen floor, instead of in place, three months after they had been requested. The freezer that had been taken of out of the storeroom, because it would not maintain a low enough temperature to store food safely, but was still being used by staff in a different part of the home to store food.

Risks to people's individual safety were not assessed or mitigated effectively to include actions for staff to support people to minimise their risks. One person who lived with epilepsy did not have an epilepsy care plan. There was an NHS information sheet in their care plan which gave information about what staff should do if somebody has a seizure but there was no personalised care plan about what could trigger this person's seizures and how they should be supported during and after a seizure. The person knew what could trigger a seizure, but this information was not captured in their care plan. This person wore a splint on their hand for extra support, but there was no record in their care plan to say the person wore the splint, or about how staff should support the person to apply it to their hand.

Staff did not understand the purpose or benefits of using prescribed equipment to minimise the risks of sore skin and did not use it effectively. One person at risk of sore skin had a temporary 'repose overlay' on their mattress. The overlay is a temporary measure until people have a permanent pressure-relieving mattress. The overlay was dirty and flat and was laid on top of the person's permanent pressure-relieving mattress. Staff's wrong use of the temporary mattress on top of the permanent mattress showed their lack of understanding of the purpose and benefits of using equipment appropriately. Another person was prescribed a pressure-relieving cushion to sit on, to minimise the risk of sore skin. On both days of our inspection, we saw the pressure-relieving cushion was on the floor in the person's bedroom and the person was sat in an armchair on an ordinary cushion.

Staff did not use their training in safe moving and handling techniques to minimise risks to people's safety.

We saw the deputy manager and another member of staff used an unsafe and improper technique to support a person to stand. They put the person's frame in front of them, and took hold of the person's pyjama bottoms to support the person to stand. They did not initially explain to the person why they needed to stand up, which might have better motivated the person to stand independently. Staff had not recognised the risk their practice posed to the person or to themselves.

The provider had failed to ensure the proper and safe management of medicines. Since our previous inspection, the provider had changed to an electronic medicines management system, but staff had not received the training they needed to be confident in using the system. A staff member who was responsible for administering medicines told us they had attended an in-house training day, but had not received the further training as planned. Staff reported their level of confidence in using the electronic system as 'four out of ten'.

Staff did not manage or administer medicines in line with the guidance from the National Institute of Clinical Excellence (NICE). Two people were prescribed a medicine for 'as and when required (PRN), but there was no protocol in place to guide staff about when it would be appropriate to administer this medicine. One person was prescribed their medicines to be given in food, but there was no risk assessment around how this should be done safely, although the person shared their home with people who lived with dementia and were at risk of picking up other people's food. There was no record to demonstrate staff had sought advice from a pharmacist to check which foods the medicine could be safely mixed with.

Some people were prescribed medicines that needed to be given 30 to 60 minutes before other medicines. Staff assured us they always administered medicines at these prescribed intervals, but the electronic recording system was not able to distinguish this. It showed that all the person's medicines had been given at the same time at 8.45am. One person was prescribed a medicine in a patch format, which should be applied to different parts of the body on a regular cycle, because of the risks associated with a reaction to the patch. The deputy manager was aware of these risks but staff had not recorded on a body map where they had applied the patch to ensure the known risks were mitigated.

Out of 13 medicines we checked, the stock balances for six medicines did not match the amount the records calculated should be available. Records showed that there should be zero of one medicine in stock, but there were 39 tablets. Another record showed there should be 117 tablets in stock, but there were 120. A third record showed there should be 39 in stock, but there were 64. The deputy manager told us they could not identify from the electronic system why there were gaps in records or apparent errors of recording.

The provider had failed to ensure risks related to the prevention and control of infection were minimised. Some areas of the home were not clean and the décor had not been well maintained, which made it difficult to keep clean. The crash mat in one person's room was ripped, and could not be cleaned effectively. Another person's bedroom was noticeably dirty. The floor was not clean, the rugs had marks on them, the bed linen was stained and the waste bin was overflowing. The person who slept in this room had put a towel over the stained pillow case. The person told us the cleaner had not been into their room for two days.

There were signs displayed explaining 'how to wash your hands effectively', but only one of four communal bathrooms and toilets we looked at had any soap or paper towels in them and the hand driers were broken or switched off. Only two of four toilets contained toilet paper. Where people had hand basins in their bedrooms there was no soap or hand towels. Where people had en-suite toilets, there was no toilet paper. In one communal bathroom we found the toilet over-seat was dirty and stained with faeces underneath. The toilet over-seat was still dirty and stained at our second inspection visit, three weeks after our first visit.

There were no toiletries in people's en-suites. The deputy manager told us people's toiletries were kept in the 'locked cabinets' in the shared bathrooms. We found the one of the 'locked cabinets in a communal area was not locked and did not contain people's personal toiletries. It contained a stock of disposable razors, disposable gloves and aprons and a cleaning product. The cleaning product was in an accessible area, and could have been hazardous to a person's health. It should have been stored safely in line with the Control of Substances Hazardous to Health Regulations 2002.

This was a breach of Regulation 12(2)(a)(b)(d)(g) and (h) of the HSCA 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

The provider did not ensure there were sufficient numbers of suitably skilled staff to support people to stay safe and meet their needs. Staff told us the provider had decided that one member of staff per five people was 'sufficient'. The staff rota showed there were three staff on duty each morning from 7.45am until 3.45pm, to support the 16 people who lived at the home. However, one staff member did not start until 9.00am on three days a week. This meant that on three days a week the provider was not meeting their own identified staffing levels for over an hour and a half at a key time of day when people needed assistance to get up. When we asked one person if there were enough staff they answered, "There was at one time." This person told us they had not gone out for 'two to three months', because there were not enough staff to support them. Their daily records showed the person had not been out for three weeks, even though the person wanted to go out.

The provider failed to recognise the importance of using a dependency needs analysis to decide how many staff should be on duty, to minimise risks to people's safety. A deputy manager told us that up to five people needed the support of two staff, depending on their health on a particular day. From mid-morning until after lunch, one of the three care staff prepared lunch, which left only two care staff to make beds and support people. A deputy manager told us, "Working with two staff is a risk, because it is not viable. There is no slack. The rota is being looked at to make it safer and more viable." The recently appointed deputy manager told us they had asked for and had been allocated a kitchen staff to work from 9am until 2pm, to enable a member of care staff to support people. However, this arrangement had only lasted for one week.

From our time spent at the home, and our observations, we found there were times through the day when people did not receive the attention from staff they needed to engage in meaningful occupation, because there were not enough staff to meet people's identified needs. On the second day of our inspection, by lunchtime, the beds were not made and a delivery of frozen food was left in crates in the corridor for more than 40 minutes, because there were not enough staff to put it in the freezer promptly.

This was a breach of Regulation 18(1) of the HSCA 2008 (Regulated Activities) Regulations 2014: Staffing.

Inadequate

Is the service effective?

Our findings

At our last inspection we rated this service Good in effectiveness. Since that inspection there had been changes in how the service was managed. At this inspection, we found the provider had not taken all reasonable measures to ensure people were supported effectively. We have rated the service inadequate in effective.

Consent to care and treatment was not always sought in line with legislation 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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The provider did not understand the MCA or their responsibilities under the Act and they had not ensured staff understood and acted within the principles of the Act. The provider had applied to deprive a person of their liberty, but their mental health care plan stated they had full capacity to make their own decisions. The application was not approved, but staff had nevertheless deprived the person of their liberty. The person had capacity to make their own decisions, even if their decisions were deemed 'unwise' by others, but the person told us they were prevented from going out on their own. They told us, "They won't let me out on my own because of my epilepsy. They won't let me out of the door because I'm epileptic" and "I feel like I am in a prison".

This was a breach of Regulation 11(1) of the HSCA 2008 (Regulated Activities) Regulations 2014: Care and treatment must only be provided with the consent of the person.

Improvements were required in staff's practice to ensure people were supported to live healthier lives and receive the healthcare support they needed to maintain or improve their health where appropriate in line with advice from a healthcare professional. One person's care plan showed they had been advised by a healthcare professional in December 2017 to ask their GP for topical creams and support tights, to improve the flow of blood to their legs. When the person revisited the healthcare professional in May 2018 they had queried why the prescriptions had not been fulfilled and why the person was not wearing the compression tights. Staff had asked the person's GP and had sent an email to the GP chasing up the prescription on 28 February 2018. However, there was no evidence that any further attempts had been made by staff to ensure the prescription was fulfilled to meet the person's healthcare needs.

In December 2017, the healthcare professional had also advised they needed to be encouraged to lose some weight for the benefit of their health, but this advice had not been included in their care plan. The person's eating and drinking care plan had been reviewed on a monthly basis with 'no changes' recorded. There was no healthy eating plan in the person's care plan and we did not see the person offered any healthy snacks

during our inspection.

Improvements were required in staff training and in assessing people's needs to ensure people received care and support in line with the expected standards, as advocated by the National Institute of Clinical Excellence (NICE). People's care plans did not contain sufficient guidance for staff to ensure people were supported consistently and effectively. Staff did not receive appropriate training to mitigate risks to people's well-being.

One person lived with epilepsy. Their care plan included basic information about epilepsy, but it was not tailored to the person as an individual. It did not explain the signs for staff to be aware of that might indicate the person was about to experience a seizure, or the individual impact of a seizure on the person. The person had insight into their own condition, but their knowledge was not recorded in their care plan. They would not have been able to communicate their knowledge verbally to staff about the support they needed, in the event they experienced a seizure. Records showed staff had not received training in supporting a person with epilepsy.

Improvements were needed in ensuring people were supported to eat and drink enough to maintain a balanced diet. Records showed one person had lost 5kg in weight between being admitted to hospital in January 2018 and May 2018, but on 29 May 2018, we did not see this person being offered any nutritional snacks between lunch and tea time. Staff had implemented a food and fluid chart to monitor how much the person ate, and referred the person to a healthcare professional, but their eating and drinking plan was not dated. The only written guidance for staff was to, 'give choices' and 'ensure normal intake'. The care plan failed to identify what was a 'normal intake' for the person, whether the weight loss was a natural progression of their illness, or the actions staff should take to support the person to gain the weight they had lost.

The provider was registered to provide accommodation and personal care for older people and people who lived with dementia. However, they did not ensure staff had the skills or competence to deliver good and effective dementia care in line with the current best practice guidance. Care staff's induction included shadowing experienced staff and training. New staff who had not worked in care previously had training in the fundamental standards of care, as set out in the Care Certificate. Staff attended training in subjects that reflected most people's needs, such as moving and handling, food hygiene and dementia awareness. However, we saw staff did not demonstrate they understood their training and some people received inconsistent support that did not meet their needs. A deputy manager acknowledged that staff needed more support. They told us, "We are trying to get more training in place to give them more confidence with people."

On the first day of our inspection visit, a member of staff was absent and had been replaced by staff from the provider's other home. The two staff on duty did not demonstrate knowledge of people's individual needs for support and people's care plans were not sufficiently detailed to enable them to know people well. Staff did not use their training in dementia awareness effectively and did not engage with people about topics that might interest them. One member of staff put on loud music and danced around the room. Only one person in the room was sufficiently engaged to clap in time to the music. Later in the day, the second member of staff stood close to the wall at the side of the room, watching people. The senior on duty did not challenge the staff's lack of effective engagement with people who lived with dementia.

Staff did not explain choices or encourage people to eat well at lunch time, particularly for those who lived with dementia. A member of staff told us people were asked what they would like to eat from the day's menu in the morning and the menu was written on the wall, but there were no pictures to support people

who lived with dementia to make a choice. People were not always shown the different meals which would have given them a better understanding of their options. People who required special diets, such as soft meals, were not always offered a choice, as only one soft meal was prepared. When people finished their main meals, staff took the plates without offering people a second helping.

The provider and staff had not considered people's individual needs in line with good dementia care guidance for privacy, peace or comfort. People's individual needs were not met in the use, adaptation and decoration of the premises. There were no pictures, direction signs or memorabilia to support people with dementia to recognise where they were. The toilet nearest to the lounge, which was the easiest and most private for people to access independently, was locked for no obvious reason.
There had been no thought as to how the communal rooms were used. The small sitting room at the front of the building, which could have been used by people who wanted a quiet space with a view, was locked. We were told it was used by the hairdresser, visiting healthcare professionals and visitors. It contained miscellaneous items, such as the medicines cabinet, the hoist battery charger, footplates from wheelchairs and a pile of odd socks. This restricted people to a single large, open plan communal area encompassing the dining room, large lounge and a small sitting area, with five doors off leading to the bedrooms. People, staff and visitors all walked through the room throughout the day. The chairs were all arranged around the edge of the room, which gave the appearance of a waiting room. When the television was on in the small sitting area, people in the large lounge could hear it. There was no recognition by staff that the dramatic music and voices of the television might be disturbing for people who lived with dementia. When music was played in the large lounge, people in the small sitting area could hear it over the television.

The provider had not recognised the risks involved in the recent changes in the management of the service or taken action to ensure important information was shared effectively. The staff team did not work together to deliver effective care and support. The deputy manager told us there was no written structure for handover between the staff shifts, so that information about how people had been, their appetites, moods and behaviours was managed consistently. Information was only shared verbally, with notes in a diary about tasks that needed to be done and the daily records were not sufficiently detailed to give an accurate picture of people's wellbeing. Incident forms were not always been completed when an incident occurred, or could not be found on the day of our inspection. The manager was no longer working at the home, and several different senior staff had been responsible for the management of the home and people's safety in the previous six weeks. There was a risk that important information about people's needs would be overlooked.

Requires Improvement

Is the service caring?

Our findings

At our last inspection we rated this service Good in caring. Since that inspection there have been changes in how the service is managed. At this inspection, we found the provider had not taken all reasonable measures to ensure people were cared for by staff that understood and respected people's individual needs. We have rated the service requires improvement in caring.

Improvements were required to ensure people felt cared for. The provider had not ensured people's needs for privacy and dignity were respected or promoted in their bedrooms. There was a lack of thought about the importance of the environment to people's wellbeing and people's bedrooms did not provide a homely, comforting place for people to spend time. In one person's bedroom the curtains were hanging down, because the hooks had come off the track. One of the person's pictures was propped on the floor behind their commode and a picture frame of family photos was propped on a radiator shelf, out of sight when the person was in bed. Nobody had thought to hang the pictures on the wall so the person was able to see them easily. Their bedroom contained a wheelchair which did not belong to the person, but the deputy manager could not explain why it was in the person's bedroom.

In another person's room there was nothing to demonstrate their personality or interests. There were no pictures, photos or other personal belongings. The deputy manager told us the person was at risk of damaging their possessions when they were agitated, but no thought had been given as to how to support the person to be safely surrounded by their possessions. There was nothing in the room to remind the person of their lifetime's experience or memories. The curtain had been stuck down across the curtain rail and could not be moved, which meant there was no natural light in the room. This person suffered with poor mental health, but nobody had thought how a lack of natural light might affect their mood. The walls were completely blank and the light did not work. The person's breakfast tray with dirty dishes was in their room, which was evidence the person had eaten their breakfast in the dimly-lit and impersonal room. Staff had not considered or acted to ensure the person's wellbeing when they were in their bedroom.

There was no respect shown for people's personal possessions and no thought given to the appropriateness of household necessities. We saw one person's underwear was left damp and screwed up on top of the washing machine. The poor quality of the household linen showed thoughtlessness and would not make people feel valued. In the linen store there was a ripped quilt and only seven towels for 16 people. The texture of the towels was rough and hard and not suitable for people at risk of sore skin. By the second day of our inspection, the provider had obtained a supply of new towels. However, the old rough towels were still on the shelf in the laundry, intermingled with the new ones. Staff had not thought to dispose of the old towels and there was a risk people with fragile skin would continue to use them

Staff did not always talk about people in respectful terms. One staff member described a person as 'opinionated'. Staff did not demonstrate understanding that they worked in the people's home and failed to make sure people were supported to live as they would choose. One person's care plan stated they liked to have a bath once a week. When we asked this person if they had a weekly bath they replied, "I used to. They use the bath as a dumping ground here and the shower is no good to me." The person told us they last had a

bath, "Twelve months ago at least." On the second day of our inspection, we saw the bath nearest the person's room contained a cushion and a toilet over-seat, and was not easily accessible to the person. The provider had not ensured the bath was available to the person when they wanted it.

This is a breach of Regulation 10(1) of the HSCA 2008 (Regulated Activities) Regulations 2014: Dignity and respect.

People told us staff were caring. One person said, "They (staff) do the best they can." However, we found staff did not treat everyone thoughtfully. Staff could have done much more to care for people and improve their well-being. One person's care plan said staff should encourage the person to walk around to maintain their mobility and '[Name] only walks when encouraged'. However, we saw this person was sat on a hard dining room chair between lunch time and tea time. No member of staff invited the person to walk around or to walk to their room, where their personal possessions were. The person's relative told us they had shared information with staff at a care planning meeting, that the person liked to hold a doll for comfort, but there was not a doll in the room. The person had nothing in their hands or on the table to give them comfort or to trigger pleasant memories.

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People's care plans did not consistently contain enough information about the person to guide staff in how to maintain and improve their wellbeing. One person's care plan gave information about their favourite singer and favourite author, but another person's personal profile, that should have included, 'what is important to me' was completely blank, even though the person's relative told us they had shared this information with staff. The deputy manager acknowledged that staff needed more support to support people effectively. They told us, "We try to keep it person-centred care but the girls (staff) need more support."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we rated this service Good in responsiveness. Since that inspection there have been changes in how the service is managed. At this inspection, we found the provider had not taken all reasonable measures to ensure the service is responsive to people's needs. We have rated the service requires improvement in responsiveness.

The provider had not ensured people's care plans were reviewed and updated to reflect their changing and current needs. One person's care plan dated 2 November 2015 stated they were independent in continence care. This had been reviewed monthly and marked, 'no changes'. However on 8 January 2018 the person had been referred for a continence assessment due to changes in their abilities. On the 26 January 2018 the continence assessment professional had assessed the person required continence aids, and had advised staff to encourage the person to drink up to 7.00pm. The change in the person's needs and the advice given by the healthcare professional was not recorded in the person's care plan.

This same person had been advised by a healthcare professional in December 2017 that they needed to be encouraged to lose some weight. The person's eating and drinking care plan had been reviewed on a monthly basis with 'no changes' recorded. The healthcare professional's advice was not been included in their care plan. There was not a plan in place to support the person to eat more healthily to reduce their weight. This person's pressure care plan dated 2 November 2015 stated they were 'independent with personal care, but any changes should be documented'. The care plan had been reviewed on 28 January 2018 and marked, 'no changes', but a body map dated 26 January 2018 stated they had a red water lesion on their sacrum. This had not been recorded in the person's care plan when it was reviewed. There was a risk the person would not receive the support they needed when their needs changed.

People did not always receive the support they needed. People's sensory needs were assessed to check whether they needed glasses or hearing aids to support their communication and understanding of information. We saw a person was wearing the glasses as explained in their care plan. However, we saw the person's dentures were left on a shelf in their bedroom and the person was sat on a normal armchair seat, because staff had failed to ensure the person sat on the pressure-relieving cushion they had been prescribed with.

The provider had failed to ensure people's social and emotional needs were met by responsive staff. One person's care plan stated it was important for them to go on a weekly trip into town to buy personal items. The person's daily records since 6 May 2018 showed they had not been supported to go into town in the last three weeks. The person told us they had not been able to go into town, 'for some time' to buy the personal items they needed. They said their trips into town had stopped, because, "They have cut staff back to three, so one of them can't come into town with me because it would leave them with two" and "You have to watch television because there is nothing else to do."

People who lived with dementia were not invited or supported to give meaning to their lives in line with the standards advocated by the National Institute of Clinical Excellence (NICE). From our time spent at the

home, and our observations, we found the provider had not acted to ensure people were supported to have a comfortable and dignified life. Records showed staff had training in dementia awareness, but people who lived with dementia were not effectively supported to engage in meaningful occupation to maintain their interest or improve their wellbeing. During the afternoon of our inspection, we sat in the lounge to see how people spent their time. Two people who had capacity to choose sat in the small sitting area socialising and watching television together. One person who was dependent on staff to maintain their interest in life spent the afternoon sitting on a dining chair, but there was nothing on the table to engage their interest. Their relative had told us the person liked a doll to hold, but said that all the dolls they had brought in for their relation had 'disappeared'. The relative told us, "Staff don't seem to inspire people. They used to have musical engagement, but not now. [Name] needs something to do."

Staff were not responsive to people's needs and did not ensure people used equipment and artefacts that would give them physical and emotional comfort in line with good dementia care. We saw seven other people who lived with dementia, and were dependent on staff to maintain their interest in life, were sat around the edge of the large lounge. Staff did not engage with people in a meaningful or person centred way. No-one was offered a book or artefact to handle, or a one-to-one conversation to capture their interest. A member of staff put on loud pop music and danced around the room. One person clapped along to the music and two others briefly watched the dancing. The other four people showed no interest in the music or dancing. After ten minutes, the member of staff went off duty. They called and waved good bye as they went, but only two people were sufficiently engaged to respond. The next member of staff stood between two people's chairs with their back to the wall, where they could see across the room and clapped in time to the music. They tried to persuade one person to clap, but the person declined.

The provider did not ensure that people's complaints were listened to and responded to effectively or resolved satisfactorily. Staff knew one person was dissatisfied that they were not able to bath and were not supported to go out on their planned weekly trip. No action had been taken to improve the person's experience or their satisfaction with the service.

Prior to our inspection visit, a relative had told us they had complained in March 2018, about their relation's care and support. One of their various concerns was that their relation spent too long sitting still in one place and that other people were allowed to take possession of the dolls they had brought to the home for their relation. The provider had failed to ensure staff changed their practice in response to the relative's concerns. During our inspection, we found the person was sat on the same chair from lunch time until tea-time. They did not have a doll with them, which could have given them the comfort and reassurance they needed. The person still did not have a doll with them or in their room on the second day of our inspection. The member of staff in charge on the second day of our inspection did not know the person well enough to know they took comfort from having a doll.

Inadequate

Is the service well-led?

Our findings

At our last inspection we rated this service requires improvement in well-led. Since that inspection there have been changes in how the service is managed. At this inspection, we found the provider had not made the improvements they said they would take and had not taken all reasonable measures to ensure the service is well-led. We have rated the service inadequate in well-led.

The provider did not learn and did not take effective action to improve the quality of the service. We had previously identified that improvements were needed to the systems and processes to ensure people were supported to live in a safe and comfortable environment. At this inspection, we found the required improvements had not been made. People were still at risk of living in an unsafe environment that was not tailored to meet their needs. Safety measures the provider said they would implement had not been implemented and there was further deterioration in the premises that the provider had not identified or repaired.

The provider had not completed the repairs and replacements they had started at our previous inspection to ensure people's safety related to the premises. The provider told us they would take immediate action to improve safety and would complete all the required repairs, for example changing the window restrictors to the recommended type on a rolling programme, starting with the rooms of those people who were identified as most at risk.

The window sill and wall in one bedroom had not been completely repaired. Tamper-proof window restrictors had not been obtained and installed across the home, as the provider had assured us they would do. Additional bedrooms had broken window catches, broken stays and broken restrictor chains. The window on the half-landing was not restricted and opened wide enough to enable a person to step out of it. The lock to an external door leading out from one bedroom was broken. Windows in three bedrooms were obviously poorly fitting and staff had tried to block the draughts with masking tape, which was peeling off and ineffective. The windows and window fittings had not been repaired in the three weeks between the first and second day of our inspection. We have imposed a condition on the provider's registration, that they must immediately repair the unsafe windows and take other action to ensure the security of the premises and ensure people's safety.

Staff told us there should be a maintenance book in the office, but they did not know where it was on the day of our inspection. The provider and maintenance man did not know where the book was, but it was visually obvious there was a backlog of maintenance requests not attended to. The deputy manager's audit action plans for February and March 2018 showed staff had requested the provider replaced or repaired the dishwasher, the microwave, the fly screen and electronic fly killer and outer door of the freezer. We saw all these maintenance requests were still outstanding on 29 May 2018.

Governance and performance management systems were not reliable or effective and the systems were not regularly reviewed to ensure risks were identified and managed. The provider had not ensured staff understood their responsibilities to regularly check people were supported safely and effectively.

The guidance and systems available to staff to maintain a risk free environment were inadequate. At our last inspection, the manager had told us small repairs and things like light bulbs were replaced promptly, but we found this was not the case. At this inspection, we found four light bulbs not working in areas people accessed. The provider had not implemented a management 'walk-around checklist', to include day-to-day maintenance checks that they told us they planned to implement. In the absence of a maintenance request book, there was a lack of evidence to demonstrate whether or when staff had requested replacement light bulbs. The deputy manager did not know the light bulbs needed replacing.

Systems for identifying, capturing and managing organisational risks and issues were are ineffective. The provider's audits did not ensure risks to people's safety were identified and mitigated. The deputy manager's infection prevention and control audit of 30 April 2018, identified that there was liquid soap and paper towels available at all sinks. However the audit activity had failed to ensure staff maintained good practice at all times. People were not supported to maintain effective hand hygiene. On 29 May 2018, we found only one out of four communal bathrooms shower rooms and toilets, and none of the en-suite facilities, had any soap and paper towels.

Staff did not demonstrate awareness of good food safety practice. The deputy manager's audit to check that food was stored safely was inadequate and could not have assured the provider that risks related to food storage were minimised. The audit did not check that staff understood their food hygiene training. The kitchen check records on 29 May 2018 showed that staff had recorded the freezer temperature as -24degrees centigrade throughout May, including the 29 May 2018. However, the thermometer in the freezer was broken so it did not show what the temperature was. There was no evidence to show whether or when staff had reported the thermometer was broken. A member of staff told us, 'no-one knew' when it had broken, but staff had continued to record -24 degrees centigrade on the kitchen records. On the second day of our inspection, we saw a delivery of frozen food was sitting in crates in the corridor for more than 40 minutes. There was a risk the food could have thawed, but staff put the frozen food into the freezer without first checking each item was still at a safe temperature for storage.

The deputy manager's food storage audit did not include two freezers in an outside store. The chest freezer in the outside store was so frosted up that the seal on the door was not working effectively. Food in the freezer had not been covered so had freezer burn. We saw the temperature of the upright freezer in the outside store was only -11degrees centigrade, which was warmer than the temperature needed to store food safely. A member of staff told us this freezer had been removed from the internal store room because it would not stay at a safe temperature, and was not safe to use. However, staff had continued to use it in a different location to store food, which was not safe practice and not included in the quality assurance audit checklist.

Audits of people's care plans had not identified that when senior staff created a care plan they had not dated it. Improvements were needed in transferring healthcare professionals' advice and staff's knowledge to people's care plans each time they were reviewed, to include updated guidance for staff to minimise risks to people's health and wellbeing. The provider had not observed staff's practice effectively, to ensure they understood their roles, responsibilities and put their training into practice. Audits of people's bedrooms did not identify when improvements were needed to ensure their bedrooms were homely and reflected their personalities and interests. The audit records that demonstrated people were supported to manage their own money were taken to the provider's other home and were not available at this home where the person lived. We have asked the provider to send us records of cash accounts and balances for those people who the provider supports to manage their money, to ensure they are supported appropriately.

This is a breach of Regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014: Good

governance.

There was not a registered manager in post and had not been a registered manager in post since December 2016. The provider had appointed two managers since the registered manager had left, but neither of them had registered with us. The provider had not informed us, by way of a statutory notification, how the service would be managed in the absence of a registered manager.

This was a breach of Section 33 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

The provider had not ensured the staff who managed the home in the absence of a registered manager, were supported and able to meet the legal requirements of a registered person. We had not received all the statutory notifications that should have been sent to us. The provider had not informed us when they had been authorised to deprive a person of their liberty, in their best interests.

Management of the service was reactive, not proactive. The deputy manager did not have time to lead the service, provide effective support to staff or understand the unique and individual needs of the people who lived in the home. The provider's arrangements for the leadership and safe management of the service were ineffective. The deputy manager told us, when the manager left in May 2018, staff were left to 'just manage'. They said, "The girls need more support here. They feel isolated without support so they need more structured management here." The deputy manager was also the deputy manager of another of the provider's homes. They told us three times a week they started their shift in the other home, then visited Chasewood at School Lane to deal with any immediate issues, and then returned to the other home to finish their shift. By the second day of our inspection, another deputy manager had had been appointed to manage the home. However we saw that staff did not respect the deputy manager's authority. A member of staff did not follow the deputy manager's instructions in respect of the safe storage of food.

Engagement with people and staff was minimal. Staff did not feel the provider listened to them or understood their concerns. The provider did not respond when staff requested that broken items and equipment were repaired or replaced. The provider's actions sent a message to staff that they did not trust the staff. The provider would not tell staff the door code to let themselves into the building. A senior member of staff told us, "Staff don't have door entry code, so have to wait to be let back in if they go out to the laundry, supplies cupboard or freezer room."

The provider did not engage effectively with people and relatives and did not invite or respond to feedback. A relative told us they had not been invited to meetings or to take part in a survey to make their views known. The provider had not implemented the satisfaction surveys for people and relatives that they told us they would implement, to make sure improvements focused on what was important to them.

The provider did not act in partnership with other agencies. The local authority commissioners had written to the provider to remind them that pre-admission assessments of needs should only be undertaken by a person with the skills and competence to do so, to ensure the service was able to meet people's needs safely and effectively. The provider had invited a person to have a trial period at the service, against the advice of a deputy manager who had assessed the service was not able to meet the person's needs. This action was a contravention of the provider's agreement with the local authority commissioners.

When we inspected the provider's other service in April 2018, we found there were similar breaches of the same Regulations. The provider had not learned from our inspection or taken action to improve this service, in light of our findings at their other service. In May 2018, we found the provider was in breach of the regulations at this service.

When we returned to check on what urgent actions had been undertaken on 18 June 2018, the provider had assured us verbally, and had already assured us in writing, they would not admit new people to the service, until they had made fundamental changes to the safety and quality of the service. After our meeting, the provider admitted a new person to the service for respite care on 18 June 2018. We have no confidence the provider will take the actions they have said they will make to improve the service.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured people were treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had unlawfully deprived a person of their liberty, in contravention of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not taken all reasonable measures to minimise people's individual risks and risks related to the premises, medicines management and infection prevention and control.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure there were sufficient numbers of suitably skilled staff to support people to stay safe and meet their needs.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Section 33 HSCA Failure to comply with a condition There had not been a registered manager in post for since December 2016.

The enforcement action we took:

We issued a fixed penalty notice to the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems of governance and leadership were inadequate and did not minimise the risks to people receiving a safe, effective, caring, responsive and well-led service.

The enforcement action we took:

We issued a warning notice to the provider.