

M & C Taylforth Properties Ltd

Chaseside Care Home

Inspection report

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Date of inspection visit:

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23 April 2021

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23 July 2021

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Chaseside Care Home is a residential care home providing personal and nursing care to 19 people aged 65 and over at the time of the inspection. The service can support up to 22 people.

People's experience of using this service and what we found

We found breaches of legal requirements in relation to the safe and proper management of medicines and the management of risk. We made a recommendation about ensuring staff recruitment records were complete. We found some shortfalls in relation to infection prevention and control. There were sufficient numbers of staff deployed to meet people's needs. People felt safe and were protected against the risk of abuse.

We found breaches of legal requirements in relation to quality assurance and records. The provider's systems to assess, monitor and improve the service had not identified the shortfalls highlighted in this report. We received good feedback about the culture of the service and the management team. We received mixed feedback from relatives about communication with the service during the pandemic.

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 good (published 23 September 2020).

Why we inspected

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 inspection was prompted due to concerns at the provider's other location. We carried out this inspection to make sure people were safe.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at 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 comprehensive inspection, by selecting the 'all reports' link for Chaseside Care Home on our website at www.cqc.org.uk.

Follow up

We will request an action plan for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our safe findings below.

Requires Improvement ●

Chaseside 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 Care Act 2014.

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 carried out by one Inspection Manager, an Inspector and a Specialist Professional Advisor in medicines management on the first day. One Inspector carried out the inspection on the second day. Another inspector worked remotely, reviewing care records.

Service and service type

Chaseside Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. 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. The registered manager was also the provider.

Notice of inspection

This inspection was unannounced on the first day. The second day of the inspection was announced.

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. The provider was not asked to

complete a provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We spoke with two people who lived at the home and a visiting relative. We spoke with six members of staff including the provider, manager, care workers and the cook. We carried out observations in communal areas to see how staff interacted with people and checked the premises to ensure they were clean, hygienic and a safe place for people to live.

We reviewed a range of records. This included multiple people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records related to the management of the service, including policies and procedures were reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at policies and procedures, care records and asked the provider for details about people's care needs. We also spoke with nine people's relatives over the telephone, to gain feedback about their experiences of the service.



Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- The provider had not ensured medicines were always managed safely and properly. During the inspection we witnessed unsafe administration practices, found medicines were not always stored in line with manufacturers' and clinical guidance and found inconsistencies in people's medicines records. Additionally, we found the provider could not evidence staff training and competence to administer medicines.
- Management of controlled drugs was not in line with legal requirements. Controlled drugs are medicines which are subject to additional controls because they may be misused. We found controlled drugs were not all stored in line with legal requirements and some could not be accounted for. Records for controlled drugs did not provide a clear audit trail because staff had not completed them to the required standard. Additionally, we found a page of the controlled drugs register had been torn out and we were not able to ascertain what the page related to, because the index page had not been kept up to date.

The provider had not always ensured the safe and proper management of medicines. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider took action following our feedback to make improvements. They reviewed their processes for the safe management of medicines and provided evidence to support improvements were being made.

Assessing risk, safety monitoring and management;

- Risks to people's health and safety were not always managed effectively. For example, we saw people had been assessed as being at risk of pressure sores, swallowing difficulties and diabetes. Records available to show risks were managed safely were inconsistent. Records of actions taken by staff to manage risk did not consistently evidence risk was managed safely.
- Risk assessments and care plans did not always provide sufficient information to manage risks to people safely. At times the information recorded was contradictory and confusing. However, we spoke with staff at the home who were able to describe how they supported people safely.
- Risks around fire safety had not been assessed and managed effectively. We reviewed the fire risk assessment for the service. The risk assessment had not been carried out by a competent person. Following the inspection, the provider commissioned an external company to carry out a fire risk assessment for the service.

The above matters demonstrated a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- The service was staffed sufficiently to meet people's needs safely. One person told us, "There's enough staff. Always someone around if I need help." The manager told us they had expressed concerns to the provider about staffing levels in a morning, when staff were busiest. In response, the provider had increased staffing to ensure people's needs could be met.
- The provider's had safe systems for recruitment of staff. However, they had not ensured they kept all records related to staff recruitment which were required. This included full employment histories and references.

We recommend the provider reviews their recruitment processes to ensure they are meeting legal requirements in relation to records kept in respect of persons employed.

Learning lessons when things go wrong

- We could not be assured lessons were learned from adverse events. The manager and provider were able to tell us what action they took and would take in response to events, such as falls. However, they were unable to provide any evidence of analysis of accidents or incidents, or learning from these, to demonstrate how they learned from them.
- Following our inspection, the provider sent us documents to review which showed they had begun to analyse accidents and incidents. These documents also demonstrated how the provider sought guidance and advice from external professionals, to ensure they could meet people's needs safely.

Preventing and controlling infection

- We were somewhat assured that the provider was meeting shielding and social distancing rules. The provider was supporting people living with dementia who did not always understand the need for social distancing. The registered manager was aware of good practice guidance related to infection prevention and control.
- We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. We found some areas of the home which had not been thoroughly cleaned or where thorough cleaning and disinfection would be very difficult.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.
- We were assured that the provider was preventing visitors from catching and spreading infections.

Systems and processes to safeguard people from the risk of abuse

- People we spoke with, and relatives we spoke with felt the service was safe. A relative told us, "The home seems perfectly fine to be honest. [Family member] seems safe." Another commented, "[Family member is safe and well cared for, I'm sure".
- People were protected against the risk of abuse or improper treatment. Staff had received training to recognise abuse and knew how to escalate concerns, including to external agencies. The provider had a policy and procedure to guide staff on their responsibilities and action to keep people safe.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider's systems to assess, monitor and improve the quality of the service had not identified and addressed the shortfalls highlighted in this report. We reviewed the provider's quality assurance systems. This included audits and checks on various aspects of the service. We found the audits lacked detail and had not identified issues we raised during the inspection.
- Records related to people's care were not always accurate and up to date. We found some care plans and risk assessments included a good level of person-centred detail, however, others were not up to date or were missing important information about risks to people and their care needs. Staff did not record care delivered to people or incidents consistently.

The provider had not ensured the maintained accurate contemporaneous records in respect of each service user and their care and treatment. The provider's quality assurance systems had not identified and addressed the shortfalls highlighted by our inspection. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager and staff were experienced, knowledgeable and familiar with the needs of people they supported. Staff were enthusiastic and had a clear understanding of their roles. A staff member told us, "Management are good. [Provider] is passionate."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others

- The manager had created a culture that was open, inclusive and put people at the heart of the service. One person spoke very fondly of the manager and told us, "I love it here. We've had a lot of laughs." Another person commented, "I couldn't be happier. The staff are very caring. Nothing is too much trouble. Staff were committed to providing quality person-centred care. They spoke positively about the service and the provider. We observed positive interactions between people and staff. We found the service was well-organised, with clear lines of responsibility and accountability.
- The service worked in partnership with other agencies to ensure people received care which met their needs. We saw records which showed the service worked with a variety of external professionals, including GPs, district nurses and Speech and Language Therapists. Guidance and advice from professionals was included in people's written plans of care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider engaged with people, relatives and staff. We saw minutes of meetings which showed people who lived at the home and staff were consulted regularly on a variety of topics.
- We received mixed feedback from people's relatives about communication. Some relatives felt staff had engaged well with them during the pandemic, whilst others felt communication needed to be improved.

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 had a policy and procedure to guide staff on their responsibilities and action they should take when something went wrong.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider had not ensured medicines were managed safely and properly. 12(1)(2)(g)</p> <p>The provider had not ensured risks to people were assessed and mitigated. 12(1)(2)(a)(b)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider's systems to assess, monitor and improve the service had not been operated effectively. 17(1)(2)(a)</p> <p>The provider had not maintained accurate and contemporaneous records in respect of each service user and the care, treatment and decisions taken in relation to their care. 17(1)(2)(c)</p>