HC-One Limited

Chaseview Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 11 May 2017. At this inspection a breach of legal requirements was found of Regulation 12 HSCA RA Regulations 2014 Safe care and treatment around the safe management of medicines. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. We had also received information from members of the public who were concerned about the safety of people who lived at the home. This report only covers our findings in relation to those requirements and the safe question. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Chaseview Nursing Home on our website at www.cqc.org.uk.

Chaseview Nursing Home provides nursing and residential care for up to sixty people. At the time of our inspection there were forty nine people living at the home. At the last comprehensive inspection we issued the provider with a warning notice to improve the way they managed medicines to ensure that people's needs were met safely. At this inspection we saw that some improvements had been made but that further improvements were needed. We saw that the provider had implemented systems which meant that staff recorded when people did not receive their medicines as prescribed. However, these were not always followed fully to ensure that further errors were avoided. They also did not always take action to ensure that people had not been harmed when they had not taken their medicines. Similarly, when incidents were recorded which could mean that people were at risk of abuse these were not always reported to the relevant agencies to protect people.

Other risks to people's health and wellbeing were assessed and managed. People were supported to move safely and any equipment that they used was regularly checked to ensure it was safe. There were enough staff to meet people's needs and to keep them safe in communal areas. The provider continued to try to recruit new permanent staff because they recognised that people did not always feel as confident with agency staff.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

People did not always receive their medicines as prescribed. They were also not always protected from harm or abuse. The systems which had been put in place to reduce the risk of harm to people had not always been followed or managed effectively. Some other risks to people's health and wellbeing were assessed and managed. There were enough staff to meet people's needs.

Chaseview Nursing Home

Detailed findings

Background to this inspection

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

We undertook an unannounced focused inspection of Chaseview Nursing Home on 7 September 2017. This inspection was completed to check that improvements had been made to meet the legal requirements described in the warning notice which was about medicines management. This inspection visit was completed by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

On this occasion we had not asked the provider to complete a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, we gave them the opportunity to do so during the inspection visit and used the information to assist us to come to our judgement.

We used a range of different methods to help us understand people's experiences. People who lived at the home had varying levels of communication. We spoke with seven people and also observed the interaction between people and the staff who supported them throughout the inspection visit. We also spoke with five people's relatives about their experience of the care that the people who lived at the home received.

We spoke with the registered manager, an area manager, the deputy manager, a nurse, three senior care staff and three care staff. We reviewed care plans for nine people to check that they were accurate and up to date. We also looked at the systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement.

Requires Improvement

Is the service safe?

Our findings

At our last comprehensive inspection we found that medicines were not always managed safely to ensure that people received them as required. This was a breach of Regulation 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. We issued the provider with a warning notice to improve the way they managed medicines to ensure that people's needs were met safely. We told the provider that improvements must be in place by 2 August 2017. At this inspection we found that some improvements had been made but that further improvements were needed.

People did not always receive their prescribed medicines. We saw that there were occasions when agency staff did not administer four people's medicines at night. For example, one person had not received their medicine for five nights in a row. We saw that staff recorded an increase in this person's distressed behaviour during this time which may have been caused by the omission. In addition we saw that some other medicines were not administered because there was not stock of the medicine in the home. We saw that on another occasion the same person had not had a different medicine for three days and no action had been taken to follow this up for two days. When we spoke with one member of staff they told us the action they had taken, and the medicines arrived for the person on the day of inspection.

There were systems in place to monitor the medicines administration records (MAR) to ensure that medicines were given. One member of staff we spoke with told us they had noticed that the medicines had not been given. They had recorded this on the MAR and had reported it to senior care staff. When we spoke with the manager they told us that the action that they had taken was to ensure that the same agency staff had not worked at the home since the occurrence. However, the manager was not aware of all of the missed medicines we identified. Also, no other action was taken to ensure that the risk to people was minimised. For example, the provider did not contact healthcare professionals to seek guidance about the impact of the omission on the person and what action could be taken to remedy this.

This evidence represents a continued breach in Regulation 12 of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

When people had not received their medicines this was not always reported as safeguarding concerns to the local authority as required. There were other instances when people were not safeguarded from harm and the risk of abuse. One person's relatives told us about an incident that had occurred. The family were informed of an injury and given an explanation by the manager. However, this injury had not been seen by staff and the manager had not completed a full investigation, including exploring other explanations. No immediate action was taken by staff to protect the person from additional harm. When we spoke with the manager they told us that they were delayed in reporting it to safeguarding because they had been too busy. In addition we saw that when people had bruising which was unexplained this was not always reported. One relative told us, "The staff told me that my relative had a bruise on her arm. They didn't know how it happened but they recorded it on a body map." We saw that this had not been reported to safeguarding. When we spoke with staff about their safeguarding responsibilities we found that they were aware of the signs of abuse. They told us that they would record their findings and report to senior staff. However, we

found that these records were not always reviewed and reported.

This evidence represents a breach in Regulation 13 of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.
The systems that were in place to assess, monitor and mitigate risk to people's health and wellbeing were not always effectively operated. We saw that when there were errors in the management of medicines these were not always reported and responded to as defined by the provider's procedures. This meant that there was a continued breach in regulation 12. We also saw that the provider's safeguarding procedures were not always followed or adhered to and this also led to a breach in regulation 13. The provider had been in breach of this regulation at the focused inspection in October 2016 and had been issued a warning notice to make improvements to their safeguarding procedures. In the focused inspection in March 2017 and the comprehensive inspection in May 2017 we found that they had made improvements and that referrals were being made to protect people from harm. However, at this inspection we found that not all of these improvements had been sustained.
This evidence represents a breach in Regulation 17 of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

Other concerns about medicines management from the last inspection had improved. We saw that when medicines which were prescribed to be given 'when necessary' or 'as required' were administered, this was recorded clearly. It included what dose was given and the reason why, which meant that staff would be able to determine whether another dose could safely be given. Medicines with a short expiry were dated when they were opened. This meant that staff could ensure that the medicines had not passed their expiry date and were still effective. Medicines were also stored safely within the recommended temperature ranges; this included medicines which should be stored in a refrigerator.

Other risks were assessed and managed and staff were given guidance of how to support people safely. People were supported to keep their skin protected from harm by staff who understood how often they needed to move their position and what equipment they required. One relative we spoke with said, "When my relative had an appointment staff encouraged them to stay in bed longer so that they wouldn't be sitting in one position for too long. They are very good with this". We saw that when people needed support to move this was done in a safe way. For example, two staff supporting people using equipment. Some people had equipment in their rooms to alert staff if they had got out of bed independently. This was so that staff could attend to them to ensure that they received the support they needed. We found that these mats were in place and had all been checked to ensure that they worked. Staff were also able to tell us how they assisted some people to receive their food in a specialised way to avoid the risk of choking. There were records in place to demonstrate that staff followed the guidance.

There were enough staff to ensure that people had their needs met. We saw that people did not have to wait and that they had their needs met promptly. One relative we spoke with told us, "We used to be concerned when people did not have any care staff with them in the communal areas. They have now increased the numbers of staff and someone is there all the time now. Now we feel that our relative is safer". One member of staff said, "The staffing levels are a lot better than they were. We have had more staff and now we can support people better". Some relatives we spoke with told us that they felt less confident when there were agency staff supporting people. One said, "I am confident the staff know what they're doing to keep my relative safe. The only problem is with the use of agency staff because they don't know people as well and also my relative doesn't recognise them. We had a meeting last night and I know they're struggling to get permanent staff." When we spoke with the manager they recognised that recruitment continued to be difficult. They told us that they had recently employed a number of permanent staff and they were putting on events to try to attract more.

The provider had followed safe recruitment procedures to ensure that staff were safe to work with people. One member of staff we spoke with said, "Before I started they took two references, including from my most recent employer. They also did police background checks and looked at documents which proved that I could work in this country".

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure the proper and safe use of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The systems and processes in place did not effectively protect people from abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The systems and processes in place to assess, monitor and mitigate risks to people's health and wellbeing were not always effectively operated.