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

Summary of findings

Overall summary

Chaseview Nursing home provides accommodation, personal and nursing care for up to 60 people. There were 45 people living in the home at the time of our inspection.

This unannounced inspection took place on 11 May 2017. At our last unannounced inspection on 9 February 2017, multiple regulatory breaches were identified and the service was judged to be 'Inadequate' and placed into 'Special Measures' by CQC. The purpose of special measures is to:

•Ensure that providers found to be providing inadequate care significantly improve.
•Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
•Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

This meant the service would be kept under review and inspected again within six months. We told the provider they needed to make significant improvements in this time frame to ensure that people received safe care and treatment from a sufficient number of staff that was responsive to their changing needs. We also told them that they needed to ensure that effective systems were in place to monitor the quality and safety of the service and drive improvements.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

At this inspection, we made the judgement that the provider had made sufficient improvements to take them out of special measures but some further improvement was needed to ensure the management of medicines was safe and their internal monitoring was effective in identifying when errors had occurred.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that medicine administration was not always safe and some people were not protected from the harm associated with their prescribed medicines. Staff did not understand the legal requirements for depriving people of their liberty to keep them safe and temporary restrictions on people waiting for

assessment did not provide staff with guidance.

Risks associated with people's care had been assessed but their management plans did not always reflect recent changes in their support needs. People's level of support had been re-assessed and amendments had been made to the staffing levels to ensure people's needs were met by a sufficient number of suitable recruited staff.

Staff understood how to protect people from abuse and poor care and how to assist them to leave the building in an emergency.

Staff training update had improved and there were arrangements in place to support staff with their development. Mealtime arrangements had improved and people with specialist nutritional needs were supported safely by staff with the training and competency to do so. People were provided with choices from a varied menu and regularly offered drinks. The advice and expertise of healthcare professionals was sought and followed by staff.

People were supported by kind staff who engaged with them and promoted their dignity whilst respecting their dignity. Relatives were able to visit whenever they wanted and were acknowledged warmly by staff. Staff knew people well and provided care which met their preferences.

There were activities for people to enjoy if they wished and they were given opportunities to reminisce with staff about their previous life experiences. People and their relatives knew how to raise concerns if they felt the need to do so.

The provider had been open and honest with people, relatives and staff about previous problems within the home. There was an audit programme in place to monitor the quality of care and an action plan to ensure improvements were made.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. People's medicines were not managed or administered safely. Staffing levels had improved to provide people with safe care. Recruitment processes ensured that staff were suitable screened before working with people.

Is the service effective?

Requires Improvement

The service was not always effective. Staff had not always understood the training they received on legal requirements about consent and restriction on people's freedom. Staff ensured people with specialist feeding systems were supported correctly. People received support from other healthcare professionals to maintain their wellbeing.

Is the service caring?

Good

The service was good. Staff provided kind, polite and considerate care to people. People were encouraged to maintain their independence and staff respected their privacy and promoted their dignity.

Is the service responsive?

Good

The service was responsive. People were asked to provide information about their likes and dislikes to enable staff to provide care in the way they preferred. People were supported to spend their time doing what they enjoyed. Relatives felt empowered to raise their concerns.

Is the service well-led?

Requires Improvement

The service was not always well led.
There was no registered manager in place as required. The systems the provider had in place had not identified the medicines error that had occurred. Regular meetings to update relatives on the changes taking part in the home were taking place. The provider was displaying their rating in line with our requirements.

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection visit took place on 11 May 2017 and was unannounced. The inspection was undertaken by three inspectors and a pharmacy inspector.

On this occasion, we had not asked the provider to send us 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 offered the provider the opportunity to share information they felt was relevant. When we were planning the inspection we contacted colleagues at the local authority and care commissioners to discuss their views on the home. We looked at the information we held including safeguarding referrals, comments from relatives and healthcare professionals and the statutory notifications the provider has to inform us about. We receive statutory notifications about any important information which affects the care of people and the way the service is operated.

We spoke with five people who used the service and eight relatives. As some of the people living at Chaseview Nursing Home were unable to speak with us we observed the care provided in the communal areas of the home to understand people's experience of care and support.

We spoke with ten members of care staff, the turn around manager, the deputy manager and the area director.

We looked at seven care plans to see if people were receiving the care planned for them. We also looked at documents relating to the management of the home and three staff files to check the recruitment processes were suitable.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 9 February 2017 we identified serious concerns about the safety of people living in the home. At the inspection on 11 May 2017 we found improvements had been made in respect of staffing levels and risks however we identified further concerns with the management of medicines.

We looked at how medicines were managed which included checking the Medicine Administration Record (MAR) charts for 11 people. Although there had been some improvements in the management of medicines we found that due to a series of errors and failures by the service to identify these had been put at risk of harm. We saw that this person had not had their prescribed medicine on two consecutive occasions immediately prior to our inspection. A member of staff told us this was because they had run out of stock despite the pharmacy delivering adequate stock for the month. On further investigation we found that the person had been given double the prescribed amount of this medicine for at least 11 days. The person's MAR had been incorrectly amended to increase the medicine dosage however this had not been signed or dated and no reason was recorded to explain the increase. When changes are made to a person's MAR it is good practice that the amendment is signed and dated with a second member of staff confirming the accuracy. This had not been done. We alerted the management team in the home of our concerns immediately and the person was checked by their doctor to ensure they had not suffered any immediate harm.

We found that another person who had not had their medicine according to the prescriber's directions. The medicine was a cream to be applied twice a day; however the MAR chart was documented once a day. No reason was documented to explain why it was only applied once a day. We further noted that the cream had not been applied for the first two days. A reason was documented that it was 'not given…prescription does not specify where to apply'. This meant the person did not receive their medicine as prescribed and potentially could delay the time taken for the medicine to be effective.

There was supporting information for staff to administer medicines when people were prescribed a medicine to be given 'when necessary' or 'as required'. However, for medicines prescribed to be given as a variable dose such as 'Take one or two tablets' we found that the actual amount given was not always recorded. This is important in order to ensure that if another dose is required then staff would be able to determine from the available records whether another dose could safely be given.

When people were prescribed a medicated skin patch to be applied on different parts of the body the available records did not always show where the patch had been applied. This is particularly important for people prescribed pain relief patches. One person's records had not been completed on one occasion. This would ensure staff could check that the old patch was removed before applying a new patch and to make sure the site of application is rotated to minimise side effects.

Arrangements were not always in place to ensure that medicines with a short expiry were dated when they were opened. We found that eye drops with a short expiry date had not been dated when opened. We also found that one person had more than two bottles of the same eye drop open and in use. Neither bottle had

been dated when opened. This meant that there was an increased risk of medicines being used longer than the expiry date and they may no longer be effective.

Some medicines were not always stored within the recommended temperature ranges for safe medicine storage. We observed eye drops that should be stored in a refrigerator were stored on the medicine trolley and therefore were at risk of no longer being effective due to incorrect storage.

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

People's risks associated with their health and support had been regularly assessed. However, we saw these did not always provide an accurate record to reflect changes that had occurred since the last review. For example we saw when people had sustained falls there had not been an immediate re-evaluation of their mobility management. We read that one person had fallen on two occasions. However their mobility needs had not been re-assessed and were not referred to in the next routine review. This meant their management plan might not always be meeting people's needs.

Staff understood their role in protecting people from abuse and poor care. Staff recognised the different types of abuse that people could be at risk from and explained to us the actions they would take to pass on their concerns. One member of staff told us, "I wouldn't hesitate to tell the manager if I thought someone was not being looked after properly".

Staffing levels on the nursing unit had been increased since our last inspection and with 21 people living on this floor of the home we saw this had had a positive impact for their support. Relatives we spoke with confirmed that the increase in staffing meant their relation was receiving more attentive care. One relative told us, "It's much more positive here. I'm glad you came in, no one was listening to us. The staff are much happier and are under much less pressure". Another relative said, "There weren't enough staff before to do simple tasks like bathing but that has changed and I can honestly say, it's great". A member of staff agreed and said, "It's a million times better now. It's better for the people who live here, it's a different place altogether". Another member of staff explained, "I worked here before and I used to go home crying because we were so short staffed. Since I came back it's much better". We saw that staff spent more time with people and had time to be receptive to their needs in a more timely manner.

There was a recruitment drive underway and some temporary, agency staff were being deployed. A member of staff told us, "The agency staff are loads better. If we give feedback on the ones who aren't good, this is taken on board and they don't come again". The area director told us they planned to maintain a level of staffing 15% above the number required to provide continuity during staff leave and sickness. We spoke with new members of staff who confirmed that there were recruitment processes in place which were completed before they were able to start working. Staff told us they provided information about their previous work history, references and had to wait for the completion of their police background checks prior to taking up their employment. We looked at three recruitment records which confirmed that suitable processes were in place to ensure staff were suitable to work with people within a caring environment.

There were arrangements in place to maintain people's safety in an emergency such as a fire. Each person had a personal evacuation plan which reflected the support they required to leave the building as quickly as possible. We saw that equipment used in the home was maintained and serviced regularly to ensure it remained safe for people.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we identified concerns about the safety of people when they were supported to eat. We saw that two people were receiving their nutrition via a system referred to as percutaneous endoscopic gastrostomy (PEG). This system is used for people who have difficulty swallowing which increases their risk of choking. At this inspection we observed one person receiving their nutrition and saw that it was completed safely and in line with the guidance provided for them. At our last inspection we saw that non care staff supported people to eat their meals but were unaware of the action they should take to ensure people were supported safely. The area director told us that mealtime support arrangements had been changed and only care staff were able to assist people. Staff had received training to ensure they understood the importance of sitting people in the correct position before receiving their meal and staff competency had been checked. During the lunchtime service we saw that staff provided people with a choice of meal and supported and encouraged them if necessary, whilst they were eating. One member of staff asked, "Can I help you a bit", when they saw a person struggling to cut their food. We saw another member of staff sat with a person who wasn't eating and after some prompting the person regained interest in their meal. One person refused their meal and all the different options they had been offered including pudding and a sandwich. A member of staff reminded their colleagues to document the food refusal and we saw this was completed to provide accurate information about the person. This demonstrated the necessary improvements had been made.

The Mental Capacity Act 2005 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. We saw that mental capacity assessments had been completed for people who needed them. The rationale behind decisions that had been made for people to show they were made in their best interest. Staff told us that they had received training in the Mental Capacity Act 2005 however the staff we spoke with were unable to explain how they should comply with the Act to ensure people who did not have capacity were supported appropriately. This meant that staff had not understood their training.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that some people were being restricted to maintain their safety. For example some people had bedrails or sensors in place to alert staff when they were moving to reduce their risk of falling. Staff had made applications, as required to impose the restrictions lawfully. However whilst there were risk assessments in place, the provider had not provided guidance to staff on the best way to support people in the least restrictive manner whilst they waited for the assessment and legal approval. There were already DoLS authorisations in place for some people however staff we spoke with were unable to identify who was being restricted and in what way. This meant that some people may have had unnecessary restrictions placed upon them.

People were supported by other professionals when further specialist input was required. We saw one

person was accompanied by staff to see their doctor at the GP surgery and another person went with their family for a dental appointment. When people were unable to go out for appointments we saw that healthcare professionals visited them in the home. People's care plans reflected the broad range of assistance people received to support their mental, physical and psychological needs.

Staff told us their access to training and support had improved. One member of staff agreed and said, "Training is more varied. As well as the online training we've also done some face to face which was great". Another member of staff told us, "I've just done training on falls awareness. I've never done that before anywhere". Staff told us they felt supported by the new management arrangements. One member of staff said, "The acting manager is very approachable. I'm quite happy to go to her with concerns. I can also speak with the unit manager, she takes things seriously too". This demonstrated that staff were provided with opportunities to discuss their needs and concerns.

Good

Is the service caring?

Our findings

We saw improvements in the way people were cared for and supported. We received compliments and positive comments about the care people received and the staff who supported them from people we spoke with and their relatives. One person said, "They look after me, I can't grumble". A relative told us, "All of the staff are caring and they interact where they can and give a good service. I find it pleasant to come here, [name of person] is content and I am too". People we spoke with referred to an improved, calmer atmosphere within the home. The increase in staffing levels and the reduction in the occupancy levels meant staff had more time to spend with people. A relative told us, "It is so much more relaxed here. The staff were under pressure before but now they have time to sit and talk with people and it's great" We saw staff chatting with people and we heard them laughing together. Another relative said, "The staff are wonderful with my relation. They always talk to her and touch their hand to reassure them".

People were supported to maintain their dignity and privacy. One person told us, "I have my hair done every week". We heard staff complimenting people on their hair style and the clothes they had chosen to wear. A relative told us, "The staff care about people's appearance". One member of staff was heard saying, "You've just had a shower and you look lovely". At mealtimes people were offered clothes protectors if they wanted them to keep their clothes stain free. One member of staff said, "Is it okay to put an apron on you to cover your white blouse? You know what it's like if you get gravy stains on you, they won't come out". We saw that staff checked that is was okay to enter people's bedrooms by knocking first. When people were using the bathrooms, if it was safe to do so, staff left them in privacy. We saw that staff noticed quickly when people were not maintaining their own privacy, for example we saw staff responded on behalf of people who had not closed bathroom doors behind them or whose clothing needed to be re-arranged. This demonstrated that staff understood the importance of ensuring people's privacy and dignity was protected.

Staff promoted people's independence. We saw staff offering support to people but encouraging them to do as much as they could for themselves. When people got up from their chairs we heard staff checking they were alright and reminding them, if necessary to use their walking aids. Staff knew people well and recognised when they needed to support people. For example some people liked to walk but needed to sit in a wheelchair for longer distances and staff demonstrated an awareness of that.

People were supported to maintain contact with their friends and family. Relatives told us they could visit whenever they wanted and we saw visitors were welcomed and acknowledged by the staff who were familiar with them. One relative told us, "The staff know us and always make us feel comfortable when we're visiting".

Good

Is the service responsive?

Our findings

People received care that met their individual needs. When people had first moved into the home staff gained information from them about their social history, family relationships, working life and interests. This enabled staff to learn about the person and what was important to them, their likes, dislikes and if they had any preferences for their care support. Staff recognised the importance of reminiscence for people and we heard them encouraging people to talk about their past lives. We heard staff chatting with people about their families and their previous jobs and encouraged others sitting close by to join in.

There were arrangements in place to support people to spend their time as they preferred. A member of staff was employed to arrange activities for people to participate in if they wanted to. We saw people enjoying singing together and moving to the music either on their feet or whilst they were sitting in their chairs. The member of staff told us, "I'm taking people upstairs for a sing-a-long. I like to mix people on the two floors; we'll also bring people from upstairs down when we have afternoon teas". Some people were playing a more energetic game of throwing a ball through a hoop which created lots of laughter between them and the staff supporting them. The activity co-ordinator spent time with people who remained in their rooms to provide them with one-to-one support.

Staff told us communication had improved in the home. We attended a 'flash' meeting during the morning of our inspection. The 'flash' meeting was attended by staff representatives for each department in the home. The meeting was an opportunity for them to update the manager on important information. We heard staff sharing information on people, for example if a person was not as well as usual and what was planned for people to eat and do that day. A member of staff who had attended the meeting told us, "This is so helpful because it means we know what's going on and makes sure things aren't forgotten".

There was a complaints process in place to support anyone who wanted to raise concerns or complaints. People and relatives we spoke with said they felt their worries would be listened to. One relative said, "The staff know what we expect. I speak up and they put things right". Another relative told us, "I can't fault the care here. I can make suggestions and raise concerns and they listen to me".

Requires Improvement

Is the service well-led?

Our findings

There was no registered manager in post as is required. The registered manager who had been in post at our last inspection had left the organisation and had not yet been permanently replaced. A temporary turnaround manager and deputy manager had been appointed to oversee and implement the changes which were required to improve the home and quality of care. The area director told us they had advertised for a manager to take on the registration for the home but had not found a suitable candidate. The provider confirmed that the turnaround manager would remain in post to ensure there was continuity until a new registered manager had settled in.

At our inspection on 9 February 2017 we were not reassured that the provider had developed a consistent approach to the management of staffing. We found that there was not an adequate number of staff available to maintain a safe environment for people. We saw that following our previous inspections the provider had taken reactive actions to address our concerns and had not demonstrated a longer term solution to improve staffing levels. When we inspected on 11 May 2017 we saw that significant action had been taken to address the areas of concern we had identified. Relatives we spoke with praised the changes that had been made and the positive impact this had had on their loved ones. One relative told us, "There have been changes since the last CQC inspection and things are holding up and improving". Staff we spoke with also reflected positively about the management of the home. One member of staff told us, "Just having the extra staff here has made it better for people, they are much safer now". The turn around manager told us that they recognised that the complex needs of some people who had lived in the home had impacted in a negative manner on the care of others. They told us that they intended to be more discerning about admissions to the home in future and admit a limited number to ensure they could meet the needs of everyone living there. A member of staff told us, "We have the right people living here. The managers are present and we feel more together than before".

There was a quality monitoring programme in place to check the safety and effectiveness of the care being provided. Whilst we saw there were regular checks in place, the error with medicines had occurred between the monthly audits and had not been identified before our inspection. The provider's internal investigation into the error had highlighted that staff had not followed the processes in place which led to the incident not being spotted.

The ratings poster and inspection from the last inspection was displayed prominently for visitors to the home to read. Relatives told us they had been provided with regular meetings to explain the concerns we had highlighted and update them on the changes taking part in the home. Relatives told us they felt that management had been open and honest with them. We saw from the minutes of meetings that some relatives had raised concerns about the use of temporary agency staff and had been provided with reassurance from regional management staff about the checks on training that were made before staff could provide care in the home. One relative told us, "We were told that recruitment was on-going and they explained the whole recruitment process which made me feel reassured".

The provider had made significant improvements since our last inspection. Other health and social care

professionals we contacted told us the provider had communicated effectively with them to drive and embed improvements for the care of people who lived in the home. This demonstrated a willingness on behalf of the provider to listen to the concerns we raised and take action to implement change.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	the management and administration of medicines was not safe and proper.

The enforcement action we took:

Warning notice.