Purelake (Chase) Limited

The Chase

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
The Chase is a residential care home providing accommodation and personal care. The service can support up to 31 people. At the time of the inspection there were 29 people living with dementia at the service.

People's experience of using this service and what we found
There had been a lack of oversight and leadership by the provider and registered manager. Robust action had not been taken by the provider to address this. Checks and audits had not been completed on all areas of the service. High-risk shortfalls we found had not been identified and addressed. The registered manager had not always worked in partnership with other professionals to improve the service. Staff did not feel supported by the registered manager and told us communication between them was poor.

People were not always protected from the risks of harm and abuse. One incident had not been reported to the local authority safeguarding team so it could be investigated. Unsafe guidance had been provided by the registered manager to staff about restricting a person and this placed them at risk of harm. National guidance around managing the risk of the spread of infection had not always been followed. However, the service was clean, and people were being supported to see their relatives safely.

Medicines were not managed safely. Staff did not know about one emergency medicine that a person may need and stock levels could not be reconciled. Unsafe guidance had been provided by the registered manager to staff about the administration of pain relief medicines. Staff had not followed this guidance and asked people if they required pain relief before it was given. Risks to people had not always been assessed and mitigated. Guidance around how to mitigate some risks did not reflect information from health care professionals. Accidents and incidents were not analysed to look for patterns and trends and there was a risk they would occur again.

Robust recruitment checks had not been completed on new staff to ensure they were able to fulfil their roles. The provider's dependency assessments process had not been followed to ensure there were always enough staff on duty.

People and their relatives had been asked for their views of the service, but these had not been reviewed and acted on. Staff told us they shared their views with the registered manager but again these had not been listened to or acted on to improve the service. However, they told us the provider did listen to their views and had used this to make improvements.

People were relaxed in each other's company and the company of staff and there was a calm atmosphere at the service. We observed staff offered people support when they needed it and knew how to meet people's needs. Relative's told us the staff were kind and went out of their way to make sure people were happy. The provider and staff worked as a team and shared the same philosophy of care. This included supporting people to be independent and treating them with respect.

Following our inspection, the provider acted to reduce the risks to people and improve the quality of the service they received. We will check to make sure this action is effective at our next inspection.

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

Rating at last inspection
The last rating for this service was requires improvement (published 28 April 2020).

Why we inspected
This inspection was prompted by our data insight that assesses potential risks at services, concerns in relation to aspects of care provision and previous ratings. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. This enabled us to look at the concerns raised and review the previous ratings.

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 requires improvement to inadequate. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safeguarding people from abuse, keeping people safe, infection control, medicines management, staff recruitment, acting on people's feedback and completing checks to improve the service at this inspection.

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

Follow up
We will request an action plan 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.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

The Chase

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.

Inspection team
The inspection was completed by two inspectors.

Service and service type
The Chase 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service about their experience of the care provided. We spoke

with seven members of staff including the provider, registered manager, deputy manager, senior care workers and care workers. We reviewed a range of records. This included seven 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 relating to the management of the service, including safety certificates and meeting minutes were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, dependency assessments and quality assurance records. We spoke with six relatives about their experience of the care provided. We contacted five professionals who were in regular contact the service.

Inadequate

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

● People were not always safe at The Chase. In May 2021 an incident had occurred, and one person had hit another person. The registered manager had not informed the local authority safeguarding team of the incident. Following our inspection, the provider informed the local authority safeguarding team so they could consider any action required to keep people safe.

● The registered manager had assessed one person was at risk from falling from their chair. They had written a care plan instructing staff to tie the person to the chair with a belt or the belt from a dressing gown. This was restriction and restraint on the person and placed them at risk of serious harm. We asked the provider to remove the instruction from the person's records and investigate any instances of unlawful restraint. We also asked the provider to inform the local authority safeguarding team of the instruction and any times it had been followed by staff. Following our inspection, the provider conducted an investigation and found staff were unaware of the instructions and would not have followed them as they were unsafe.

The provider and registered manager had failed to consistently protect people from abuse. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● When other concerns were raised about staff's practice the provider had acted promptly to protect service users from the risks of harm. They had informed the local authority safeguarding team and CQC so the concerns could be investigated. They had also referred staff to the disclosure and barring service so they could consider barring staff from working in social care in the future.

● Staff understood their responsibilities in relation to safeguarding. They were confident to raise concerns with the provider and deputy manager and were confident they would act. One staff member told us, "[The deputy manager] would do something about it. As soon as I tell them, they will do it."

Using medicines safely

● Medicines were not managed safely. One person was prescribed emergency medicines. Healthcare professionals had put detailed guidelines in place for its administration. However, the registered manager had not arranged for staff to complete training to administer the medicine. This left the person at risk of harm. The person had not required the medicine since it was prescribed. Following our inspection, the provider took action to obtain training for staff and put interim arrangements in place to reduce the risk to the person.

● Some people were prescribed medicines, 'when required'. The registered manager had not provided information to staff about the signs they would see if the person needed the medicine, the time between

doses and the maximum dose in 24 hours. They had instructed staff to administer 'when required' pain relief to most people twice a day. This was against the instructions from people's GPs. Staff had not followed this instruction and asked people if they needed pain relief when they administered their other medicines or if the person was showing signs of pain.

● Medicines were not stored safely. At times medicines had been stored above the maximum temperature recommended by the manufacturer. No records of temperatures had been maintained during a recent spell of very hot weather. Other records showed the temperature was above the recommended maximum of 25°C. There was a risk people's medicines would not be as effective because they had become too warm. Following our inspection an air conditioner was placed in the room and guidance was provided to staff about temperature monitoring.

● Records of medicines were not always accurate and did not demonstrate people had consistently received their medicines. Records had not been maintained to confirm some prescribed creams had been applied to keep people's skin healthy. These records were put in place following our inspection. There were no records in relation to one emergency medicine and staff did not know how much had been received or when. There were some gaps in medication administration records and it was not clear if medicines had been administered or were not required.

The provider and registered manager had failed to operate effective systems to ensure medicines were stored and administered safely. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Action had not always been taken to review and reduce risks to people following accidents and incidents. For example, following an incident between two people the registered manager had not reviewed the people's care plans and put measures in place to reduce the risk of a similar incident occurring again. Accident and incidents records for June and July 2021 could not be located during our inspection. No analysis of accidents and incidents had been completed to look for patterns and trends. This left people at risk of further harm. Following our inspection, the provider reviewed accidents and incidents for June and July 2021 and referred two people to medical professionals for support.

● The registered manager had not always provided the correct guidance to staff about how to manage risks to people. One person's diabetic care plan instructed staff to check the person's blood sugar levels three times a week. A medical professional had not requested these checks or provided the equipment to complete them. Staff told us they had informed the registered manager this guidance was incorrect, but it had not been changed. The checks were not being completed and the person's diabetes was stable and well managed by staff.

● Another person had been assessed as being at risk of falling. Their care plan instructed staff the person used bedrails to reduce the risk of them falling out of bed. We met the person, who told us they did not use bedrails and had never fallen out of bed. Bedrails were not fitted to the person's bed. The person had not had any other falls. We were not assured falls risk assessments had been completed accurately and risks to people had been identified and mitigated.

● Pressure ulcer risk assessments were completed by the registered manager, however they inaccurate and did not reflect the care people needed to keep their skin healthy and intact. One person's risk assessment stated they were not at risk of developing a pressure ulcer. However, the deputy manager told us the person was at risk. The person used a special mattress and cushion to reduce the risk and their skin was healthy.

The provider and registered manager had failed to accurately assess and mitigate risks to service users. This left people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff supported people to move safely using moving and handling equipment. Staff support one person to move using a hoist. The person told us they always felt safe when staff supported them to move. We observed staff safely supporting people to use standing equipment.
● Risks to the environment had been assessed, maintenance checks were completed on various parts of the service regularly including fire checks and checks on window restrictors.

Preventing and controlling infection
● We were not assured staff were using PPE effectively in line with government guidance. The registered manager and provider told us staff did not always wear masks and a robust risk assessment was not in place around this. We observed staff not wearing masks or not wearing masks correctly. One staff member was wearing a fabric mask which was not in line with government guidance. The provider told us they would ensure staff wore face masks in future.
● We were not assured the registered manager was admitting people safely to the service. They told us people had not been required to isolate for 10 days when they moved into the service. Two people had moved into the service shortly before our inspection. Risks to everyone living at The Chase had not been assessed and mitigated. This does not reflect government guidance.

The provider and registered manager had failed to protect people from the risk of the spread of infection. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured the provider was preventing visitors from catching and spreading infections.
● We were assured the provider was meeting shielding and social distancing rules.
● We were assured the provider was accessing testing for people using the service and staff.
● We were assured the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Staffing and recruitment
At our last inspection we recommended the registered manager and provider consult national guidance about the safe recruitment of staff. Improvements had not been made and staff were not always recruited safely.

● Gaps in staff's employment history had not always been identified and action had not been taken to ensure any gaps had been explained. The registered manager had not checked one staff members right to work in the UK. We discussed this during our inspection, and the registered manager obtained this information.

The provider and registered manager had failed to complete all the required checks on new staff. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were not always enough staff deployed to meet people's needs. The provider had a process in place to assess people's dependency and determine how many staff were required to meet people's needs. It was

the registered manager's responsibility to complete the tool each month. This had not been done since March 2021. Since March 2021 new people had moved into the service and other people's needs had changed. We could not be assured there were always enough staff on duty to meet people's needs.

● Following our inspection, the provider completed the dependency tool with staff who knew people well. They told us based on their assessment one more staff member was required during the day and took action to deploy additional staff.

● We observed staff meeting people's needs, although they were busy. The provider and deputy manager also took time away from managerial tasks to support and reassure people. Staff told us when staffing levels were reduced, they were able to meet people's basic needs but did not have time to spend with people. This was an area for improvement.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements: Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider and registered manager was not leading the service and supporting staff to provide good quality care. Staff did not feel supported by the registered manager and told us they were not accessible when they needed them. They told us the registered manager was often in her office with the door closed and was not approachable. Staff did not feel valued by the registered manager, one staff member told us, "The manager is rude and aggressive in their approach. Especially if they want something done there and then". Staff did feel valued by the provider and the deputy manager, one staff member told us, "(The provider) has been absolutely fantastic. I get thanked at the end of every shift".
- Communication between the registered manager and staff was not effective and staff had not been made aware of important changes to people's care. Minutes of important meeting with staff, including a meeting to discuss medicines errors had not been kept so everyone was able to remind themselves of what had been said.
- The provider had acted when staff had not demonstrated the skills and values required to provide good care. They had followed their policies to stop unsafe staff working at the service and had referred them to the Disclosure and Barring Service when necessary. However, they had not acted robustly enough to address the concerns they had noted about the registered managers practice and these had continued.

Continuous learning and improving care

At our last inspection we recommend the registered manager and provider consult national guidance about achieving change through robust quality checks. Not enough improvement had been made and effective checks had not driven improvement at the service.

- The provider and registered manager did not have a good oversight of the quality of the service. Regular medicines audits had not been completed. This had been noted by the provider, but they had not taken robust action to ensure effective audits were completed. The registered manager had started a medicines audit in June 2021 but had not finished it. This highlighted stocks did not balance; medicines records were inaccurate and ordering shortfalls. It was not clear what action had been taken to investigate these and improve medicines management. Following our inspection, an experienced registered manager from another service competed a medicines audit. This found further shortfalls in medicines management and medicines stocks could not be reconciled.
- Care plan audits were not effective and had not identified shortfalls we found in people's care plans. For

example, areas of one person's care plan stated they did not have a 'do not attempt cardiacpulmonary resuscitation' order (DNACPR) in place. The person did have a DNACPR order in place and there was a risk attempts may have been made to resuscitate them. Disrespectful language had been used in people's care plans to describe them and their needs. Risks to people from not having care plans in place had not been identified.
● The provider audits did not cover all areas of the service and they had not assured themselves checks the registered manager had completed were effective. For example, no checks had been completed on the staff recruitment process and care plan audits had not been reviewed to ensure they were effective. Action the provider had taken to address other shortfalls highlighted during their checks had been effective. Action plans had been put in place and were reviewed as part of the next audit to check actions had been effective.

The provider and registered manager had failed to assess, monitor and improve the quality and safety of the service. This left people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At our previous inspections we identified the environment required updating, and some parts of the service were odorous. At this inspection we found improvements in the environment; an extension had been built to create a larger lounge, people's bedrooms had been re-decorated and new flooring had been installed. The provider had an on-going improvement plan in place which included changes to the garden.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
At our last inspection we recommend the registered manager and provider consult national guidance about receiving and acting on feedback to develop the service. Some action had been taken but it had not been effective in improving the service people received.

● Effective systems were not in operation to obtain feedback from people's relatives and other professionals. The registered manager told us they requested feedback from relatives several months before our inspection. They told us they thought feedback had been received but were unable to recall what it said or where they had stored it. Following our inspection, the provider found some feedback and they planned to analyse this.
● Staff meetings had been held regularly with the aim of discussing people, and any concerns staff had or improvements for the service. These meetings were not always effective, for example, staff had been reminded to wear face masks, however we observed staff were not wearing face masks all of the time. Staff told us they felt the registered manager did not listen and act on their suggestions for improving the service. Morale was low at times and staff told us, "When the manager is here it can be a really difficult environment to work in. I feel tense when they are here, it's like walking on eggshells when they are around".

The provider and registered manager had failed to operate effective systems to seek and act on feedback from service users, their relatives and staff. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Regular meetings were held with people and they were asked for their views about the food, activities and staff. Feedback from people was positive and included, 'food is lovely,' 'food is more than satisfying,' '[The staff] are good, they help me if I have a problem,' and 'Staff are very kind and polite.''. A relative had commented, 'I have seen how hard you all work to give the residents as normal life as possible,' and 'When I phoned [staff] were always polite and upbeat. It was peace of mind knowing they were safe, being fed and cared for.'

● Relatives we spoke with were complimentary about the care their relatives received. They had been supported to keep in touch with their loved ones during the Covid-19 pandemic restrictions and were now visiting regularly. They told us staff kept them informed about their relatives and knew their relatives well. Their comments included, "The staff are brilliant", "My relative is one hundred percent safe there and well looked after. The staff go above and beyond."
● Staff told us the provider and deputy manager listened and acted on their feedback to improve the service. For example, staff had commented completing all the required records was onerous and took them away from providing people's care. The provider had worked with staff to review what was needed and the number of documents they were required to complete had reduced. Plans were in place to complete further reviews of the records to ensure staff had easy access to the information they needed.

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
● Services that provide health and social care to people are required to promptly inform us of important events that happen in the service. This is so we can check appropriate action had been taken. The registered manager failed to notify CQC of an allegation of abuse so we could check action had been taken to protect people from further risks.
● The provider had correctly recognised a notification was required when someone had left the building without staff knowing. Meeting minutes showed the registered manager had not told anyone until instructed to do so, by the provider.

Working in partnership with others
● The registered manager had not always worked in partnership with other professionals to improve the service. A specialist health practitioner had offered their support to the registered manager on two occasions. Another health practitioner had offered training to develop staffs' skills. Their offers had not been taken up by the registered manager.
● Staff had developed good working relationships with the local GP surgery. A 'ward round' was completed each week and any concerns around people's health were discussed. However, staff had not always been supported to follow the advice and guidance given. A health professional told us the provider had, 'a proactive approach'. A GP told us, "I have always found the staff there very caring and compassionate to the needs of the residents". Following our inspection, the provider contacted the surgery for support to address the concerns we found.
● A visiting optician told us staff always contacted them at the right time. They said, "They do know people. Any concern, broken glasses, falls to do with the eyes, sudden loss of vision, if they think behaviour is to do with the eyes, they call me in".
● The provider had been working with the local authority commissioning team to make improvements to the service. They kept them updated about their progress and any concerns.

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 The provider and registered manager had failed to operate effective systems to ensure medicines were stored and administered safely. The provider and registered manager had failed to accurately assess and mitigate risks to service users. The provider and registered manager had failed to protect people from the risk of the spread of infection.

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider and registered manager had failed to consistently protect people from abuse. This placed people at risk of harm.

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and registered manager had failed to assess, monitor and improve the quality and safety of the service. The provider and registered manager had failed to operate effective systems to seek and act on feedback from service users, their relatives and

professionals.

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider and registered manager had failed to complete all the required checks on new staff.

The enforcement action we took:

We imposed a condition on the provider's registration.