Church Walk Health Care Limited

Church Walk

Inspection report

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Tel: 01706717400

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 11 and 16 January 2017.

Our last comprehensive inspection took place on 1 August 2014. At this inspection, we found the service had complied with all the regulations we reviewed. However, it was acknowledged by the provider that opportunities for staff training and development needed to improve to help keep people safe. At the time of our last inspection a programme of training and support was being developed to help staff to carry out their role effectively.

Church Walk offers person centred nursing care for people with complex physical and neurological conditions, including mental health needs, Huntington's Disease, acquired brain injury, early onset dementia including Korsakoffs and Frontal- temporal dementia.

The home is a purpose built two-storey building with 18 single en-suite bedrooms. The home is situated in a residential area of Rochdale and is close to local amenities. At the time of our inspection there were 12 people using the service.

The registered manager had recently left the home. An acting manager was in place and we were told that it was their intention to register with the Care Quality Commission in the near future. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service has a condition of registration that it must have a registered manager. Because the service did not have a registered manager the well-led question cannot be rated better than 'requires improvement'.

Relatives we spoke with told us that they thought their family members were safe at the service. Staff had received training in safeguarding adults. They were able to tell us of the action they would take to protect people who used the service from the risk of abuse.

Procedures were in place to help ensure staff were safely recruited. We saw sufficient numbers of staff were available to help support people's assessed emotional, social and physical needs were met, so their health and well-being was maintained.

Systems were in place to ensure the safe handling of medicines and to reduce the risk of cross infection in the service.

Staff had access to the training and support they needed to help treat, care for and support people, safely and effectively.

The service had taken appropriate action to apply for restrictions in place in a person's best interests to be legally authorised.

The service worked in partnership with other health and social care professionals. A consultant psychiatrist visited the service every week. This meant that people had access to the support they needed.

The premises was seen to be well maintained, comfortable, homely, clean, and tidy.

The atmosphere at the home was calm and relaxed and interactions between people and the staff team were seen to be frequent and friendly.

Care plans were in place to help ensure staff provided the level of support necessary to manage the identified risks. Care plans were regularly reviewed to address any changes in a person's needs.

Activities were available for people to participate in and improvements were being put in place following a review by the new management team.

A recent review of the day-to-day operation of the service had identified shortfalls. These shortfalls were in the process of being addressed, including improvements to the culture at the home.

We found that the managers and staff demonstrated a commitment to continuing to drive forward improvements in the service. People and staff were being asked their views and opinions about the service and evidence showed that these were being listened to and acted upon.

Systems were in place to show the service was under constant monitoring and review, which included external assessment.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff had received training in safeguarding adults. There were systems in place to help ensure staff were supported to report any abuse they witnessed or suspected.

Staff had been safely recruited and there were enough staff to meet people's assessed needs.

Systems were in place to ensure the safe handling of medicines and to reduce the risk of cross infection in the service.

Is the service effective?

Good

The service was effective.

The registered manager had taken appropriate action to apply for restrictions in place in a person's best interests to be legally authorised.

Staff received the induction and training they required to ensure they were able to carry out their roles effectively.

People were provided with a choice of suitable and nutritious food.

The service worked in partnership with a wide range of health and social care professionals to help ensure that people received the support, care and treatment they needed.

Is the service caring?

Good

The service was caring.

The atmosphere at the home was friendly, calm, relaxed and inclusive.

Managers and staff knew people who used the service well and had good knowledge of their needs, likes and dislikes.

Is the service responsive?

Good

The service was responsive.

A thorough assessment was undertaken before a person moved into the service. This gave individuals the opportunity to test out what the service offered to help ensure it was the right place for them.

Care records were very detailed about what action was to be taken to support each individual's personal preferences.

Opportunities were available for people to participate in activities if they chose to and on-going improvements were planned.

Systems were in place for the reporting and responding to people's complaints and concerns.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service has a condition of registration that it must have a registered manager. Because the service did not have a registered manager the well-led question cannot be rated better than 'requires improvement'.

An acting manager had recently taken up post and it was their intention to register with the Care Quality Commission.

The service had a new management team. The staff team spoke positively about the management team, who were said to be approachable, supportive and visible.

Monitoring systems were in place to help maintain and improve the safety and quality of service.

Following a recent review of the service planned improvements were in place and also a firm commitment to enhance the culture of the service.

Church Walk

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.

Before our inspection, we reviewed the information we held about the service including notifications the provider had sent to us. We contacted the local authority safeguarding and commissioning teams and the clinical commissioning group. They raised no concerns about the care and support people received from Church Walk.

We had requested the service to complete a provider information return (PIR); this is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. This was returned to us by the service.
The inspection took place on 11 and 16 January, was unannounced and undertaken by an adult social care inspector.

During the inspection we spoke with one person who used the service. This was because people had limited ability to speak with us. We spoke with three relatives and an interpreter. We also spoke with the acting manager, the operations manager, two regional operations managers, the clinical nurse manager, two nurse unit managers, six healthcare assistants, the activity co-ordinator, a chef and three members of the house keeping team.

We looked around the building and observed how care and support was provided to people in communal areas. We also reviewed a range of records relating to how the service was managed; these included three people's care records, recruitment files and staff training records.

Good

Is the service safe?

Our findings

Relatives told us that they thought their family members were safe at Church Walk. They said, "Absolutely safe I have peace of mind," "They ring me if there are any issues" and "I know [relative] is being looked after. I can phone the night staff to check [relative] is all right. [Relative] couldn't be anywhere better." The relatives we spoke with visited the service regularly.

We spoke with staff about their responsibilities for safeguarding vulnerable adults. Staff told us that they had received training in their responsibilities for safeguarding adults and how to use the whistleblowing procedure if they witnessed poor practice by colleagues. They knew they must report any concerns to their line manager or to other agencies such as the local authority safeguarding team and CQC. They also told us they felt confident the management team would listen to any concerns they raised and take any action required.

The new clinical nurse manager had previous experience in working with a safeguarding team in a hospital setting. The clinical nurse manager told us they had started to network with local authority and clinical commissioning group safeguarding leads. The clinical nurse manager was also in the process of becoming a member of the local safeguarding forum. This would help them to be aware of and share any developments in safeguarding practice.

We checked to see that staff had been safely recruited. We reviewed two staff personnel files and saw that each file contained an application form with included a full employment history, two references and confirmation of the person's identity. Checks had also been carried out with the Disclosure and Barring Service (DBS) for all applicants. The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. These checks should help to ensure people are protected from the risk of unsuitable staff.

We saw there were procedures in place to confirm that that all nursing staff maintained an up to date registration with the Nursing and Midwifery Council (NMC). This should help ensure people received care and treatment from nursing staff who met national standards and code of conduct.

During the inspection we saw sufficient numbers of nursing and health care assistants were available to meet people's individually assessed needs. There was also an activity worker, housekeepers and a cook on duty, who all helped to provided people with flexible support. The support team worked flexibly to meet the care and support needs of people who used the service.

There was always a nurse on duty at the home. Apart from the acting manager, the clinical nurse manager and the two unit managers there were four other nurses employed at the home. The acting manager told us that three new nurses were in the process of carrying out their induction training before starting work at Church Walk. The nurses were either registered mental health nurses or learning disability nurses. The service also employed 39 support workers and seven bank staff. Rotas that we saw confirmed that this was the case.

Records showed that there had been a high intake of staff during 2016. The acting manager was aware of the staff turnover and retaining staff was a priority within the improvement planning for the home.

The acting manager said that the service was using regular agency nurses. However, this would be reduced once the new nurses had completed their induction training and shadowing existing nurses. This would enable them to get to know the people who used the service and the responsibilities of the role. The acting manager also told us that they were in the process of recruiting more bank staff. This would help to ensure consistency and continuity of care for people.

We saw that the deployment of staff on the units was arranged dependent on people's individual needs. This meant that staff were rotated to work with people where their behaviours could present as challenging. This arrangement helped to ensure that staff did not become overtaxed which could impact on their performance.

People had detailed risk management plans in place to guide staff on the action to take to mitigate the identified risks. Part of the ongoing improvements to the service was to review each individual's level of positive risk taking to help ensure that people were fully optimising their independence.

We saw that the provider carried out health and safety checks of the service. The provider information return (PIR) informed us that at the organisation's last internal health and safety assessment the service scored 71% giving them an amber rating. The acting manager had recently requested another assessment. We saw that the assessment rating had improved to 82%. The acting manager told us that the outstanding issues were minor and would be addressed quickly.

We saw a business continuity plan was in place to provide information for staff about the action they should take in the event of an emergency such as a failure of the gas or electricity supply to the premises. We saw information that showed that valid maintenance and services had been carried out for gas safety, electrical fitments and fittings, the passenger lift, the passenger, fire alarm tests, emergency lighting and fire extinguishers. This helped to ensure the safety of people who lived, worked in and visited the service.

We saw that all communal areas were clean and well maintained. Systems were also in place to reduce the risk of cross infection in the service; this included the use of personal protective equipment (PPE) where necessary and regular checks regarding the cleanliness of the environment. The red bag system was used to transfer any soiled items to the laundry.

We spoke with members of the housekeeping team. They told us that recently they had been asked to give ideas about how to improve the service. They had also been given more responsibility to ensure that standards of hygiene were maintained throughout the home and observe and challenge other people's practice.

The kitchen held a 5 rating from the national food hygiene rating scheme, which meant they followed safe food storage and preparation practices.

We reviewed the systems in place for the safe handling of medicines. Only trained nurses were responsible for administering medicines and were responsible for holding the keys to the medicine's room. The acting manager informed us that supplying pharmacist's online training was made available for nurses to use in December 2016 and was being completed.

We were made aware that there had been a number of problems recently about people not receiving their

medicines in a timely manner. The management team had arranged to meet with the supplying pharmacist to help to ensure that improvements were made. This included arranging for all people's medicines to be ordered and delivered on a one month cycle to improve the efficiency of the system.

We checked the medicines on one of the units with the unit manager. There was a monitored dosage system (MDS) in place for the administration of medicines. We saw that medicines received from the pharmacy were checked in and recorded out if they had not been used. The timing of medicines being administered could be arranged to suit people's daily routines. We saw that, where a person lacked capacity to consent to their treatment, a meeting had taken place to agree that it was in their best interests to receive their medicines via a percutaneous endoscopic gastrostomy (PEG) feed.

At the time of our inspection no-one was being given controlled medicines. These are medicines which require additional safeguards to be put in place to reduce the risk of their misuse. There were no 'as required' medicines being used to support people to manage their behaviours on the unit. The unit manager told us that homely remedies were not used without authorisation from a doctor before their use; this was to ensure they were not contra-indicated with the person's prescribed medicines. No-one was self-medicating.

There were contractual arrangements in place with two consultant psychiatrists who attended the service for a fortnightly 'ward' round and would visit people at Church Walk in the event an emergency; this meant that any required changes in people's medicines could be quickly arranged.

Good

Is the service effective?

Our findings

At our last inspection it was acknowledged by the provider that opportunities for staff training and development needed improving to keep people safe. A programme of training and support was being developed to support staff in carrying out their role.

We were told all new members of staff, regardless of their role, completed a seven day induction programme before they worked with people directly. We saw a copy of the timetable for induction training programme. The induction training included a wide range of topics, which included, customer care and communication, person centred support. fire safety, equality, diversity and inclusion, nutrition and hydration, physical intervention training, safeguarding, Mental Capacity Act and deprivation of liberty safeguards as well as a wide range of health and safety topics.

We spoke with staff about the training and support offered to them. They said, "The training is good," "I really enjoyed it" and "My confidence has improved [since the training]. I am more assertive and can speak up."

We looked at the staff team training record, which showed some shortfalls in refresher training. However, we saw records that showed that the new management team were aware of this and a wide range of training was booked to take place between 16 January and 1 February 2017 to bring refresher training up to date. The acting manager said that staff had not received training in end of life care. However, they were now in the process of arranging for staff to undertake end of life passport training at the local hospice.

Records showed that the provider was registered with City and Guilds as an approved centre to deliver QCF Level 2 and 3 in health and social care. The provider had their own trainer, assessors and there was a training room, which was available for the staff team to use. This showed that the provider was committed to ensuring staff had the training they needed to support people safely and effective and their personal development.

We saw that nurses signed the registered nurse charter. The charter had been developed to set out what the employer would do to support staff and what was expected of the nurses, which included their personal accountability to the NMC code of practice.

Records showed that there had been recent shortfalls in staff supervision. However, they also showed that supervisions were starting to take place again. A unit manager said that they hoped that supervision sessions would address any shortfalls in practice to ensure that all staff returned to achieving the same expected standard of care at the service.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as

possible.

People can only be deprived of their liberty 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 were informed that all but one person had a DoLS in place.

We talked with the new clinical nurse manager who told us that they had significant experience in working with the MCA and DoLS in a previous role. They were clear about the need to act in people's best interest and identifying the least restrictive option around their care and treatment to help maximise their independence. This demonstrated a commitment to protecting and upholding people's rights.

People's needs and behaviours were diverse. Some people who used the service lived with a condition called Huntington's Disease. Huntington's Disease is an inherited progressive and can affect movement, perception, awareness, thinking and judgement. The condition can result in changes in personality, mood swings, irritability and behaviour. Other people were living with early onset type dementias' that can result in similar behaviours.

The unit managers we spoke with were very knowledgeable about people's presenting behaviours that challenged others, their individual communication needs and their personal strengths. They told us that understanding people's behaviour and interpreting it correctly was very important and it should not automatically be assumed to be negative. They said, "We treat people as individuals." They told us that small things really matter. They said, "We can tell if a person is becoming agitated and we try to divert them to help reduce anxiety and distress."

Relatives said, "They have insight into [relatives] condition. I have seen [relative] make progress and start to make relationships with staff," "Staff know how to dealt with [relatives] outbursts. [Relative] is bright and more alert and is without doubt moving in the right direction as [relatives] outbursts have decreased" and "Its amazing here, very calm."

Staff said, "I am surprised how well I can handle behaviours I didn't know I had it in me. You have to know people their life stories and listen. It is how you talk to people."

It was understood that some people had difficulties with the concept of time so they were supported to follow their own routines at times that worked best for them,; for example, it was not unusual for some people to be having breakfast when others were having their lunch. Night staff we spoke with told us that there were high levels of staff on duty during the night because some people were awake and there was also no pressure to get people up.

Some people needed support immediately and behaviours could increase if they were kept waiting. Some people were resistive to personal care and so staff would not force the issue but kept going back until the person was ready to undertake the task.

We saw that the service used a recording tool to help identify and reduce behaviours that challenged; this was known as the Lalamond behavioural documentation. The document encourages staff to think about people's behaviours, their stress factors and triggers and to look at ways to create opportunities to develop positive behaviours.

We were told that due to the complex needs of some people, behavioural plans were in place to guide staff

in the appropriate level of support and intervention individual's; where necessary this included physical intervention. Staff were provided with relevant and accredited training in Non-abusive psychological and physical intervention (NAPPI). This training was completed at induction and periodically updated to help ensure staff were following good practice so that people were kept safe. Records seen confirmed what we had been told. Staff we spoke with were clear that they were only to use NAPPI to the level of their training. A unit manager was qualified to train staff in NAPPI.

At the time of our inspection, we were informed that only low level NAPPI was being used with one person. A best interest meeting had been held in relation to this physical intervention. No-one needed support that required NAPPI Level 3. The acting manager informed us that supplementary training would be accessed if this level was required.

People at the home were cared for and treated by nursing and care staff. They also had the support of two consultant psychiatrist who were employed by the service and carried out a 'ward round' every two weeks and also a specialist consultant in Huntington's Disease. People were also registered with a local doctor and had access to other healthcare professionals for routine health checks.

A unit manager told us that as part of ideas being considered for the future, they had put forward a proposal to help improve the overall wellbeing of people through nutrition, hydration and exercise. Consideration was being given to using a local hydrotherapy pool, which would be accessible to all, and introduce a personal trainer, with experience of working with people with mental health needs.

Some people had conditions that could cause them to become reluctant to eat or experience problems with swallowing that increased the risk of choking. We were told and saw from records that, where necessary, Speech and Language Therapists were involved in the assessment and risk assessments of people's nutritional needs.

We were told that some people were fed via a PEG. We were told that nursing staff carried out the PEG feeds. Staff also received support from a nutritional nurse who also trained staff, reviewed care plans. Appropriate staff also had access training in BMI, weight maintenance, choking.

We were told about a range of other methods that were used to help ensure a person received their nutritional intake which included taking nutritional supplements, drinks spooned from a cup, using different types of cutlery and other special individual arrangements. We were given examples of where people had put on weight since they had come to live at Church Walk and the improvements it had made to their wellbeing.

We talked with the chef about people's dietary needs. The chef knew which people were at risk of choking and what their diet consisted of. They said that staff would return meals to the kitchen if they were not confident that the meals were of the right consistency and that this was the right thing to do.

We saw that there were plentiful supplies of food and drink. The chef told us they were happy with the quality of the provisions provided. Where a person was reluctant to eat an alternative meal was provided. Some people also had their meals fortified with full fat milk and cream, for example, milkshakes were fortified with cream and ice cream. The chef was also looking at preparing smoothies for people. People had access to recently refurbished dining kitchen areas.

People were provided with spacious, well maintained accommodation over two floors. People were seen to be able to access all communal areas of the home spending their time as they wished. We were told that

people's care needs were being reviewed to see if they were placed appropriately in the two units; for example, some people on the first floor might benefit from being on the ground floor so they could access the user friendly and secure garden.

We saw that the some rooms at Church Walk had been or were in the process of being refurbished or redecorated. We were told that people had been involved in choosing colour schemes around the service. One person was said to have requested tartan bed linen and this was to be sourced by the housekeeping team. We saw that each floor had a sensory and assisted bathroom into which music could be played to help people relax.

Good

Is the service caring?

Our findings

We spoke briefly with one person who used the service. They said, "They look after me and I look after them. I have a good life here."

Relatives we talked with spoke of the difficulties they had faced accessing services because their family members could at time present behaviours that challenge others. They spoke positively about their experiences of Church Walk. They said, "They do a wonderful job with respect," "Fantastic, [relative] couldn't be anywhere better" "They genuinely like [relative] and "If you are looking for someone to sing this place's praise you have come to the right person. An interpreter said, [Person] is safe. There is a good atmosphere and staff are supportive."

The atmosphere at Church Walk was calm, relaxed and the pace was slow to enable time for communication and allow people to do as much as they could for themselves. We saw that staff interacted positively with people in a respectful and discreet way. Nurses spoken with had detailed knowledge of how people wished to be supported in meeting their individual needs, which included their strengths as well as their support needs.

Staff said, "This is their home" "Listening to people is really important" and "We care for people as individuals." We saw that staff had access to online dignity champions training. The acting manager told us that 14 members of staff had signed the dignity pledge and we saw certificates displayed to support this. A dignity champion pledges to stand up and challenge disrespectful behaviour and act as a good role model. They must ensure that peoples human rights are upheld, treat people as individuals, by promoting choice, independence, empower and listen to them.

Some people's rooms were highly personalised with photographs and furnishings. However, it was recognised that this type of arrangements did not suit everyone and that others found it difficult to cope with too many objects. People had en suite facilities in their rooms which afforded them privacy. We saw some people had double beds for their comfort.

Staff recognised that supporting individuals to maintain a relationship with their family was very important and significant events were celebrated. For example, one person was supported to buy their relative flowers and cakes to celebrate special occasions, which they had done all their life. We were told that Church Walk had good links with the church next door to the home, which people could attend twice a week if they wanted to. This gave people the opportunity the time to spend with other people who were not care staff.

We saw that the provider held a national annual "Making a difference" awards scheme. This was a scheme, which enabled staff to nominate colleagues who they thought deserved special recognition. We saw that three staff had received awards: a unit manager at national level and two other staff members were regional finalists. The provider asked for feedback from staff about how they thought the awards scheme could be improved.

Good

Is the service responsive?

Our findings

We talked to both the acting and regional manager about the admission criteria for the home. The managers said that referrals were made to the provider's central database. From the database the provider would consider the services across the organisation that potentially could meet the person's needs. The referral would then be considered by the managers to assess whether they could meet the person's needs and that the person would be compatible with the existing group of people living at Church Walk.

We saw that a person was in the process of a gradual introduction to the service. They were visiting Church Walk with the staff from their current setting. This gave people and staff time to get to know one another and decide whether the placement would work before an agreement was reached to move into the service permanently. Where appropriate relatives were involved in the assessment process and information was gathered from health and social care professionals.

We looked at three people's care records. We saw that the care plans and risk assessments used covered, behaviour, cognition, psychological and emotional support, communication, mobility, nutrition, continence, breathing, medication and a number of other areas such as social support and key relationships. We saw that care records and associated risk assessments were very detailed. This meant staff had clear information to direct them in the care and support people required, ensuring their needs were safely and effectively met. People and where appropriate their relatives were involved as much as possible in the care planning process. The acting manager said that a shorter more person centred document was also being considered.

We were told that a staff handover hand over had recently been reintroduced at each shift change so that all staff were made aware of any changes in the care and support people needed. We attended a handover meeting and observed that a report was given by staff on each person. Records were also completed to confirm that information that all required checks and cleaning had been undertaken.

The new management team were aware that activities at the service needed to be improved. We saw that the activities offered at the service were under formal review. We saw that leaflets were available to people and staff for suggestions as to how activities might be improved.

We talked with the activities co-ordinator who had started to work at the home in recent months. They told us that there were plans in place to have three activities co-ordinators. We saw that the activities co-ordinator was in the process of ordering equipment such as arts and crafts materials, sensory equipment and games. The activities co-ordinator recognised that people were of different ages and ability, and activities needed to cover a wide range of diverse needs.

We saw that there was a plan of activities arranged for the week, which included a quiz, music, residents meeting, arts and crafts, memories, pamper day and baking. We saw that there was a colourful "International Month" board on the corridor. The idea was that a country would be looked at over the coming four weeks. Countries/continents included Poland, Italy, Africa and United States of America and

people would be supported to look at food, flags, music and baking which related to them. We were told by the activities co-ordinator people had helped to make the flags on the board.

People had different interests, for example, going for a takeaway and other people liked to play giant Connect 4 and Twister. We heard that some people wanted to raise money for charities that were important to them and this was in the process of being arranged by the activities co-ordinator, for example, making gift hampers as raffle prizes.

The home had their own mini bus that could be used by appropriately trained drivers to take people out. We were told that music was enjoyed by many people and was encouraged. A 'music man' visited the service once a week and some people enjoyed karaoke.

We saw that an interpreter came into the home once a week for three hours. This was to speak and engage with a person in their own language and interpret during any outside activities in which the person participated. This person was also able to engage with night staff who spoke their language. Pictorial communication aids were available for staff to use in the absence of staff who could speak the person's language.

Where people were able they were encouraged to maintain their independence, for example, we saw that some people were supported by staff to prepare and cook snacks. The service had a life skills kitchen, with cooking, dining and laundry facilities.

We saw that information was available about Church Walk available for people to read and view. This gave people information about what they could expect from the service. The service had also recently reviewed and updated the service user guide. The service user guide gave people and their relatives and other interested parties detailed information about the service.

We saw that the complaints procedure was displayed in the entrance hall. Information about how to make a complaint and who to contact if people were not satisfied with the response were also detailed in the service user guide. We were informed by the acting manager that there had been no complaints about the service.

We saw that there was a relative's forum planned to take place on 20 January 2017. In the entrance hall, there was a suggestion box and suggestion feedback forms that could be used by visitors about how to improve the service.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a manager in place who was registered with the Care Quality Commission (CQC) as required under the conditions of the service provider's registration. The registered provider had notified us that the registered manager had left the service. We were informed that it was intended that the acting manager who had worked at the home since 5 December 2016 was to apply to register with us.

The service has a condition of registration that it must have a registered manager. Because the service did not have a registered manager the well-led question cannot be rated better than 'requires improvement'.

The acting manager was a registered mental health nurse with many years' experience of working with people with complex mental health needs. A new regional operations manager and a new clinical nurse manager were supporting them in the day-to-day running of the home. The operations manager told us that they were currently visiting the service twice a week.

Managers' told us that there had been an operational review of the service and also a regional restructure of the operations management team. We were told that the new management team were actively involved in making improvements to the service. The improvements made would involve the people who used the service and staff. The focus was to redirect the service to a more person centred approach and increase people and staff's involvement in the running of the service. We saw a memo thanking staff for their help and asking for ideas for making Church Walk a better place for people to live.

The operations manager said that, "We are already starting to see staff blossom. Our aim now is to focus more on what people want and establish a firm value base which will be embedded in our culture over time." The regional operations manager said, "We want staff comfortable, confident and involved."

Nurses we spoke with said, "Some changes were needed as we were too comfortable. It will be for the better," "[Clinical Nurse Manager] is a breath of fresh air" and "Our skill mix complements each other. We play to each other's strengths."

Care staff told us, "Managers are enthusiastic and want to increase activities at the home," "Managers are engaging with us more. It is more open and the culture is definitely improving," "Team work is improving. There is no longer one rule for one and one for another" and "[Managers] are working hard to change things."

Support staff we spoke told us that recently been more motivated and morale had improved. They said they thought that staff were now being managed properly and communication was better.

We saw that the service's statement of purpose and service user guide had been reviewed and amended in January 2017 to reflect the changes to the running of the service. The statement of purpose is a legally required document, which tells people what the service does, and who for.

We looked at the arrangements in place for quality assurance and governance. Quality assurance and governance processes are systems that help registered providers to assess the safety and quality of their services..

We saw the records from the acting manager's daily walk round of the home for the previous six days. The record confirmed any issues that they had found and action that they had taken to ensure that the matter was addressed.

We saw that the acting manager met with the clinical nurse manager, the unit managers and staff from the support team at around 10am for 10 minutes to discuss what was happening that day at the service; this gave the opportunity for staff to raise any concerns they had so that they could be addressed. Where an issue was raised a discussion session was arranged for the afternoon to see what could be done to address the problem.

We saw that the acting manager and the clinical nurse manager completed a monthly return that was sent electronically to the provider. The statistical returns covered weight monitoring, pressure area care, all adverse incidents and levels of seriousness, the number of restraints that had taken place, infection control issues, falls, mandatory training, deprivation of liberty safeguard authorisations.

We saw records that showed that a staff meeting had been held on 16 December 2016 at which the new acting manager introduced themselves. We also saw minutes from the weekly management team meeting which took place on 4 January 2017. Both meetings included discussions about actions that need to be taken to make improvements at the home and risks relating to people who used the service.

Prior to our visit, we had requested the service to complete a provider information return (PIR); this is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. This was returned to us and gave detailed information about the service. It was noted that the PIR had been completed prior to the changes in the management team and priorities for the overall service had changed.

Before our inspection, we checked the records we held about the service. We found that the service had notified CQC of any accidents, serious incidents and safeguarding allegations, as they are required to do. This meant we were able to see if appropriate action had been taken by the service to ensure people were kept safe.

We also contacted the local authority safeguarding and commissioning team. They raised no concerns about the care and support people received from Church Walk though it was noted that all the people using the service did not originate from the local authority area.