Southcrest Care Ltd

Churchill House

Inspection report

745 Holderness Road
Hull
North Humberside
HU8 9AR

Tel: 01482709230

Date of inspection visit:
14 November 2018
15 November 2018

Date of publication:
30 January 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This comprehensive inspection was unannounced and took place on 14 and 15 November 2018.

At the last inspection, in September 2017, we rated the service as Requires Improvement. The provider was in breach of Regulation 11 HSCA (Regulated Activities) Regulations 2014. The provider had not consistently acted in accordance with the Mental Capacity Act 2005 (MCA) in relation to when people were unable to give consent because they lacked capacity. They had also not consulted with the local authority when there was the possibility some people met the criteria for a Deprivation of Liberty Safeguard (DoLS). We asked the provider to complete an action plan to show what they would do and by when, to improve the key question effective to at least good.

During our current inspection, we found improvements had been made. The provider had followed the principles of the MCA and people had DoLs in place. We found the provider had been compliant with this regulation. However, we found issues with recording in this area, and one DoLS application had been overlooked, which we refer to in the well-led section. We found new concerns including a lack of effective systems to monitor the safety and quality of the service provided and safe care and treatment.

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

Churchill House accommodates up to 24 older people in one building. Bedrooms are situated over two floors which are accessible via a lift and stairs.

There was a 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.

The home was generally clean and tidy, however we found some minor issues. We saw cleaning taking place, although records to confirm this, had not been kept up-to-date. There were some issues with the safety and maintenance of the environment. Staff had not had recent fire drills and water temperatures had not been monitored, to ensure these were safe.

We found two people without appropriate bed rail protectors on one side of their bed. The risk assessment for bed rails had not been detailed enough to consider how risk would be mitigated. We found another person was missing a risk assessment for the use of bed rails.

The registered manager acted promptly when we told them about these concerns and most were addressed during the inspection or shortly afterwards. However, the quality monitoring system needed to be more

robust, to ensure checks of the environment highlighted areas of risk so these could be addressed quickly. Other areas of the quality monitoring system also required development.

People did not always receive their medicines safely. We found one person's creams had not been applied as prescribed and guidance was missing for two 'as and when required' medicines, also known as PRN.

Systems were in place to recruit staff safely. However, the providers recruitment policy had not always been followed which led to some shortfalls. We also found following disciplinary action, there was a lack of records to show how one staff members skills had been monitored, to ensure they continued to be competent for the role.

Staff protected people from avoidable harm, were knowledgeable about safeguarding and able to raise concerns. They supported people to meet their nutritional and healthcare needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. We found staff were aware of the MCA and followed its principles.

Staff were equipped with the necessary skills to provide effective support. They knew people well and how best to communicate with them.

Staff were caring and friendly. We observed positive interactions from staff. They supported people to maintain their independence and treated them with dignity and respect.

There was a lack of meaningful activities provided for people. The registered manager told us about plans to improve this. We recommend that the provider follow through with these plans, to ensure appropriate and meaningful activities for people living with dementia are provided.

Staff were knowledgeable about people's needs, which meant support was provided in a person-centred way. People had care plans in place which reflected their needs.

People told us they felt able to raise any issues or concerns. The provider had systems in place to manage and respond to any complaints.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to safe care and treatment and good governance. 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.

There were some issues with the safety and maintenance of the environment.

Steps had not always been taken to assess and mitigate risk. Two people's bed rail risk assessments were not effective, and another person was missing a risk assessment.

Systems were in place to recruit staff safely, although the providers recruitment policy had not always been followed which led to some shortfalls.

People did not always receive their medicines safely. We found one person's creams had not been applied as prescribed and guidance was missing for two 'as and when required' medicines.

Is the service effective?

Good

The service was effective.

Staff had awareness of the Mental Capacity Act 2005 (MCA). They sought people's consent before providing care and support and could tell us how decisions were made in people's best interest for those that lacked capacity.

Staff were equipped with the skills and knowledge to provide effective care and were supported in their role.

Staff supported people to meet their nutritional needs and access healthcare.

Is the service caring?

Good

The service was caring.

Staff were kind and friendly and interacted positively with people. There was a relaxed and homely atmosphere within the service.

People were treated with dignity and respect. Confidentiality was

maintained and people's independence was promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a lack of stimulating and meaningful activities provided for people, although plans were in place to improve this. We have made a recommendation about this.

Staff were responsive in meeting people's needs in a person-centred way. People had care plans in place which reflected their needs.

A complaints policy was in place and people told us they knew how to make a complaint if required.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems to assess, monitor and improve the quality and safety of the service were not always effective. This had led to some shortfalls including record keeping for the application of the MCA and some safety issues in the environment.

The registered manager was approachable and involved in the running of the service.

Churchill House

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.

This inspection took place on 14 and 15 November 2018 and was unannounced. This was a comprehensive inspection, carried out by one inspector.

Before the inspection, we looked at information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually, to give some key information about the service, what the service does well and improvements they plan to make. We looked at the notifications received from the service and reviewed all the intelligence CQC held, to help inform us about the level of risk for this service. We also contacted the local safeguarding team, commissioners and Healthwatch to request their views of the service. Healthwatch is the independent national champion for people who use health and social care services.

We looked at three people's care records and five medication administration records (MARs). We also looked at a selection of documentation in relation to the management and running of the service. This included quality assurance audits, complaints, accident and incident records, recruitment information for four members of staff, staff training records and policies and procedures.

We spoke with four people who used the service and one relative. We spoke with three members of staff, as well as the registered manager and deputy manager.

Requires Improvement

Is the service safe?

Our findings

Steps were taken to ensure the safety of the premises. However, records of water temperatures were not being maintained. The registered manager told us maintenance should check and record the water temperature monthly. However, we found no records for these in the last year. This meant water temperatures were not being monitored, to ensure these were safe. We found some other safety issues with the environment. For example, a box of disposable gloves stored on top of a cupboard in the downstairs toilet, rather than locked in the cupboard, where the registered manager confirmed they should be stored. We found screws had been left on the floor outside a vacant bedroom, where the maintenance man had been working earlier. There was a risk people living with dementia may have come across these items. As soon as we brought these concerns to the registered managers attention, they were addressed.

Most risks were identified and recorded with actions taken to minimise risk where possible, including continence, medication and falls. However, not all risk assessments were effective. We identified two people's bed rails only had appropriate bed rail protectors on one side of the bed. The risk assessments did not provide enough detail to consider what the potential risks where. Following the inspection, the registered manager confirmed new bed rail protectors where in place. We also found one person was missing a risk assessment for the use of bed rails. The registered manager confirmed this was completed following the inspection.

Generally, the home was clean and tidy, however during the inspection we found some minor issues with the environment. For example, we found a used continence product on top of the cupboard in the downstairs toilet. This was immediately disposed of. There was a cleaning schedule in place to ensure areas were regularly cleaned. However, the records for when some areas had been cleaned had not always been maintained. We saw cleaning taking place throughout the day and people told us cleaning took place daily.

A maintenance and refurbishment plan was in place and we saw that works were being completed to update the home. A radiator had been moved the day prior to our inspection, so plans were in place to wallpaper a small area this had affected. The registered manager told us some bedrooms doors were being altered, to ensure they closed properly following the fitting of a new carpet. A bathroom was out of use because the bath lift was waiting to be replaced. This limited people's choice, as only a shower was available. The registered manager told us they were hoping to have a new bathroom fitted, but plans had not been confirmed. The shower stool in the main bathroom had some rust underneath which meant it could no longer be cleaned effectively and posed an infection control risk. The registered manager confirmed a new one had been ordered following the inspection.

Fire drills had not taken place in the last year. Staff told us they had fire training as part of their induction, but this meant new staff had not had the opportunity to practise a fire drill. Fire safety checks were carried out and people had personal emergency evacuation plans in place, although we found one person's required updating, following a deterioration in their health. The registered manager updated this straight away.

Systems were in place to recruit staff safely, but there were shortfalls in staff records and the recruitment policy had not always been followed. This included carrying out a Disclosure and Barring Service (DBS) check. A DBS check allows employers to make safer recruitment decisions and prevent unsuitable people from working with vulnerable people. We found that one member of staff had started work before their DBS check had been completed. They were supervised, to minimise any risk during this time. However, a risk assessment had not been completed to evidence this, as stated in the providers recruitment policy, therefore the recruitment policy had not been followed in this instance. Similarly, the risk assessment had not been completed where DBS checks indicated staff had past convictions. The registered manager told us they were assured of the staff's good character and would ensure the assessment of risk was documented.

One member of staff who had been employed had been disciplined for two issues, and we found they had not completed training in one of these areas. The registered manager was aware of potential risks which could arise due to their past performance, however they had not monitored and responded to this through formal means, including training and competency assessments. This meant there were no records to show this member of staff had the competence and skills to provide effective care, following the disciplinary issues being raised.

Medicines were not always administered safely. We found one person's creams had not been applied as prescribed. One record indicated the cream had not been applied on the last five occasions it was due. Staff recorded when they administered medication on a medication administration record (MAR). We found other medicines had been recorded correctly. Staff supported people with their medicines in a personalised way. Only trained staff, whose competency had been assessed, administered people's medicines. Staff supported people to ensure their medicines were reviewed by appropriate healthcare professionals, to ensure they had been prescribed the medicines appropriately. Protocols were in place to guide staff about how to administer 'as and when required' medicines (also known as PRN), however we found two medicines were missing guidance. The registered manager confirmed these were now in place following the inspection.

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

Despite the above shortfalls, people told us they felt safe. One person said, "I feel safe, there are no two ways about that." Staff could protect people from the risk of abuse. They had received safeguarding training and were aware of different types of abuse. Staff worked in partnership with other health and social care professionals to protect people and ensure they received appropriate support.

There were sufficient numbers of staff available to meet people's needs. During the inspection, we saw there were enough staff around to support people.

Accidents and incidents were recorded appropriately and appropriate action taken. For example, seeking appropriate medical attention. The registered manager had oversight of these, so any patterns and trends could be identified to reduce the likelihood or impact of these reoccurring.

Systems were in place to protect people from the spread of infection. Staff told us they were provided with and used personal protective equipment (PPE); we saw these were available to staff.

Good

Is the service effective?

Our findings

At the last inspection, in September 2017, we found the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not consistently acted in accordance with the Mental Capacity Act 2005 (MCA), in relation to when people were unable to give consent because they lacked capacity. They had also not consulted with the local authority when there was the possibility some people met the criteria for a Deprivation of Liberty Safeguard (DoLS).

The 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the principles of the MCA were being followed and improvements had been made since our last inspection.

Decisions had been made in people's best interest for those that lacked capacity. For example, direction had been taken from people's GP before medication was given covertly. However, records for other decisions made in people's best interest had not been documented. We have referred to this in the well led section because this was an issue with records.

Staff were knowledgeable about the MCA and supported people to make their own decisions wherever possible. They were aware of the importance of seeking people's consent and promoting people's choices.

People were supported by staff who had completed a range of training to equip them will the skills and abilities to carry out their roles effectively. Staff had received an induction upon starting in their role. One person told us, "The new staff seem to know what they are doing and are spending time getting to know everyone."

A large proportion of staff were new so were not due an appraisal. Two staff who were due an appraisal had missed these due to the registered manager prioritising new staff induction and staff supervision. Staff were provided regular supervision and the registered manager assured us plans were now in place to ensure staff received an annual appraisal. Staff told us they felt supported in their role and confirmed they had regular supervision. A member of staff said, "I have had supervision, it was really good. It is good to know you are doing things well." Another told us, "The registered manager has listened to me and supported me."

Staff had the skills and abilities to communicate effectively. Staff were aware of how to communicate best with people, dependent on their needs and preferences. We observed staff communicating with people as

described in their care plan. For example, we saw staff being patient and waiting for people to respond, as well as ensuring they were at eye level with people.

Staff worked in partnership with health professionals and supported people to maintain their health needs by accessing appropriate services and support. For example, Staff liaised with GP's and district nurses to seek their advice and input. This was reflected within peoples care records. One person told us, "The staff call the doctor if I need it."

Staff supported people to maintain a nutritional diet of their choosing. We saw people were offered a choice at meal times and people confirmed they were offered alternatives. One person told us, "If there is nothing on the menu you can ask for it and they will do it for you." We saw people sat where they preferred to eat their meal, whether this be in the dining room, lounge or their bedroom. People were supported with eating and drinking if needed. The food looked hot and appetising. One person said, "It's nice, hot food." Most people told us they enjoyed the food, however one person told us it was variable.

Good

Is the service caring?

Our findings

People were supported by kind and caring staff in a calm and homely environment. People were comfortable in their surroundings and looked relaxed. One person told us, "It feels like home." Another said, "It's nice, I like it here."

We observed staff were kind and caring and spoke to people in a friendly manner. We saw positive interactions in the dining room at meal times between staff and people who lived at the service. People we spoke with gave positive feedback about staff. One person told us, "The staff are nice." Another said, "I have no complaints about the staff; they are brilliant."

There was a positive culture and good morale amongst staff, which impacted positively on the people living at the service. One member of staff told us, "I love caring."

People were supported to maintain relationships with family and friends. People told us their visitors were made to feel welcome. One person said, "Staff ask my family if they want tea or coffee." We saw a couple was supported to maintain their relationship and to follow their preferred routines as a couple. For example, they were supported to get ready in the morning, in time for them to both have breakfast together.

Staff respected people's privacy and maintained their dignity. Staff could tell us ways they would do this, whether it was respecting someone's personal space or when supporting them with personal care. We saw they knocked and waited for permission before entering people's bedrooms. People confirmed they did this normally. One person said, "They [staff] always knock." Another told us, "Staff always knock and respect my privacy."

Staff valued the importance of maintaining people's independence and promoted this where possible. Staff could tell us how they did this. For example, encouraging people to do small tasks for themselves like washing their own face when supported with personal care. One person said, "They let me do the bits I can."

Staff were aware of equality and diversity and respected people's individual needs and circumstances. For example, one person told us they preferred to remain in their bedroom. Staff supported this and developed a positive rapport with the person, who told us they had "good banter" with staff. Another person was supported to maintain their relationship with their spouse; staff respected their privacy.

Staff were aware of the importance of maintaining confidentiality and could tell us ways they did this. People's care records were stored securely in the office.

The registered manager told us they were aware of advocacy services and would support people to access these if needed. Advocates are independent representatives, which help people's views to be heard.

Requires Improvement

Is the service responsive?

Our findings

People's needs where assessed before they received a service to ensure they could be met. Staff were knowledgeable about people's individual needs and were responsive in meeting their needs in a person-centred way. Staff had regard for what was important to people and had awareness of their preferences and preferred routines.

In recent months there had been no activities programme provided because the activities coordinator had left. Staff told us they had not had time to engage with people to provide meaningful activities as the service had been working to overcome staff shortages. Occasional activities such as guest singers had been provided, which some people told us they enjoyed. One person said, "I don't think there is much. We used to like doing chair exercises and bingo. Sometimes some children visit and we have a sing song."

During the week of our inspection a new activities coordinator had started. The registered manager explained the new activities coordinator had been introduced to all the residents and had been spending time getting to know them, finding out their interests and what they would like to do. There was no activities programme, but the registered manager explained they wanted to develop a more flexible approach to activities, so residents could engage with activities in smaller groups or a one to one basis. Following the inspection, the registered manager updated us that the new activities coordinator had also left and they were in the process of recruiting another.

We recommend the provider and registered manager seeks best practice advice regarding appropriate and meaningful activities for people living with dementia and to follow through with their plans for more personalised activities.

People's care plans contained detailed and personalised information about their abilities, health needs, likes and dislikes. This enabled staff to provide person-centred care, and support people in line with their preferences. We spoke with staff who could tell us details about people's needs, the support they required, and the person's preferred routines. We saw this matched what had been recorded in people's care plans. For example, we saw one person drinking from a beaker and sat with their favourite soft toy and these details were captured in their care plan.

Information was available within people's care records regarding their end of life wishes and preferences. We saw people's care plans were reviewed and kept up to date. One person said, "I have seen my care plan and I'm happy with it."

People were protected from discrimination and their values and beliefs were respected. We saw people's rights and choices were promoted and valued.

A complaints policy was in place, for if complaints were received; although there had not been any since the last inspection. People told us they would be able to speak to staff or the registered manager if they had any issues or concerns and these would be addressed at the time. One person said, "If I have a complaint, I tell

them and they deal with it. I don't have many."

Requires Improvement

Is the service well-led?

Our findings

Some systems were in place to assess and monitor the quality and safety of the service, but these were not always effective. This meant the opportunity to drive improvement had been lost and risk had not always been minimised. Monthly audits were completed by the registered manager, but these were inconsistent and did not focus on what was being monitored. For example, care plans were audited, but there was no system to show what was being checked and what improvements were needed. This had led to a missing risk assessment for the use of bed rails. The registered manager completed this following the inspection.

Systems to monitor the safety of the environment had not always been effective. Gaps in the cleaning schedules, the completion of maintenance jobs, or environmental risks which we noted in the safe section had not all been identified. The registered manager acted promptly when we told them about these issues and most were addressed during the inspection or shortly afterwards. However, the quality monitoring system needed to be more robust to ensure checks of the environment highlighted areas of risk so these could be addressed quickly.

There was no system in place to consider when Deprivation of Liberty Safeguards (DoLS) applications may need to be reviewed. This meant for one person, who had previously consented to their care, when their cognition deteriorated and they were no longer able to consent to their care, the requirement for a DoLS application was not reconsidered and therefore not made. The registered manager made the relevant application during the inspection.

The system used to monitor the quality of people's care records did not refer to the Mental Capacity Act 2005 (MCA) or DoLS. This led to similar shortfalls in the recording of how the MCA had been applied, for people that could not consent to their care. We found documentation had not been completed to evidence how decisions had been made in two people's best interest for the use of bed rails. Another person had a sensor mat in place, but there was no record of this decision being made in their best interest.

There were also gaps in the systems to monitor staffing and support, which had led to two staff appraisals being missed, appropriate risk assessment documentation not being completed and records for staff competency not being reviewed or completed following disciplinary action.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Feedback was gained from people who used the service, relatives, and professionals to drive quality within the service. We saw that feedback from people and relatives had been analysed and an action plan formed, which was displayed on a notice board.

The registered manager told us there had been problems with staffing in the past and this had been overcome with a large proportion of new staff being recruited. There was now a positive team morale and culture within the service. A member of staff told us, "There has been a lot of changes, but it's now settled."

There was a sense of team work and staff told us they felt supported. A member of staff said, "It's a good team and everyone is helpful."

The registered manager was based at the service. People knew who they were and told us they were approachable. One person said, "[Registered manager's name] seems quite decent. I see them now and again." A member of staff told us, "[Registered manager's name] is approachable and easy to communicate with."

Staff told us communication was good. The provider communicated with staff and people living at the service through a variety of means including meetings. The registered manager told us meetings for residents and relatives were not well attended, so they would look at more accessible ways of communicating changes within the services.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Everything reasonably practicable was not carried out to mitigate risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not implemented effective systems or processes to assess, monitor and improve the quality and safety of the service provided to people. The provider had not maintained an accurate, complete and contemporaneous record in respect of each service user, including an accurate record of all decisions taken.