Care Quality Commission

Coate Water Care Company (Church View Nursing Home) Limited

Church View Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We carried out this inspection over three days on the 11, 12 and 15 May 2015. The inspection was unannounced. Our last inspection to the service was in June 2013. During the inspection in June 2013, we looked at people's care and welfare, the numbers of staff on duty and the systems in place to enable staff to do their job effectively. The service was compliant in all areas considered.

We had received information regarding serious concerns, which related to the management of five people's care. The information indicated that these people had developed significant pressure ulceration and one person was found to be lying in soiled bedding.

Church View Nursing Home provides accommodation to people who require nursing and personal care. The home is registered to accommodate up to 43 people. If the twin rooms were used for single occupancy, 36 people could

Summary of findings

be accommodated. On the day of our inspection, there were 29 people living at the home. Church View Nursing Home has bedrooms on the ground and first floor. All rooms have en-suite facilities. A passenger lift is available for people with mobility difficulties. There is a communal lounge and dining area on each floor with a central kitchen and laundry room.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

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

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Staff were not consistently responsive to people's needs and there were a high number of people with significant pressure ulceration. Proper interventions were not in place to ensure each person's wound and skin pressure area care was managed effectively. Care plans were not person centred and were difficult to follow. Records did not demonstrate a clear understanding of the Mental Capacity Act 2015. Not all people were properly assessed in terms of the risks to their safety. Those people at risk of malnutrition were insufficiently monitored and had limited food intake. There was little evidence they had been supported to have alternate foods or high calorie snacks between meals.

There were not enough staff to meet people's needs effectively. Whilst call bells were answered in a timely manner, some people had to wait for assistance and not all people were given the time they needed. Not all staff showed a caring approach to people. There was limited interaction and some staff talked to each other rather than to the people they were supporting. When assisting people to eat, staff did not explain the food content or make pleasantries to enable a more pleasant experience.

Staff had not consistently signed the medicine administration record to show they had administered people's medicines as prescribed. Protocols were not in place regarding medicines to be taken "as required". This did not ensure these medicines were administered in accordance with the prescriber's instructions.

Staff told us the training opportunities available to them were good. However, records showed staff were not up to date with their training in key areas such as safeguarding people. There was little training in relation to older age or people's health care conditions. Registered nurses had not been given the opportunity to develop their clinical skills. Staff told us they felt well supported by each other and the registered manager. They had received formal supervision to discuss their role and a new supervision system was in the process of being implemented.

There were detailed and comprehensive arrangements in place to ensure the safety of the environment and the equipment used. However, audits had not been undertaken to identify shortfalls in provision and to monitor the quality of the service. Prior to March 2015, there was no analysis of accidents and incidents to identify possible trends or triggers, to minimise further occurrences.

Staff were clear about their responsibility to report any suspicions or allegations of abuse. People felt safe and they would inform a member of staff if they were unhappy with the service they received. The registered manager told us people were encouraged to give their

Summary of findings

views about the service on an informal basis. More formally, surveys had been sent to people to gain their views. The information had not been coordinated, as it was expected more surveys were due to be returned.

The registered manager told us the home was not operating as well as they wanted it to be and they had an action plan in place to ensure improvement. Following our inspection, the registered manager confirmed that senior managers had agreed to place a voluntary embargo on the home. This meant there would be no more admissions to the home until improvements had been made.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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.

There were not enough staff available to meet people's needs effectively. Whilst call bells were answered quickly, not all people were given the time they needed and were kept waiting for assistance.

Whilst there were detailed risk assessments in relation to the environment not all risks to people's safety had been properly identified and addressed.

Staff did not consistently sign the medicine administration records to show people had taken their medicines as prescribed. Protocols were not in place to ensure medicines to be taken "as required" were administered in line with the prescriber's instructions.

Robust recruitment procedures were in place, which ensured people were supported by staff with the appropriate experience and character.

Is the service effective?

Inadequate

The service was not effective.

Not all staff were up to date with their training regarding key topics such as safeguarding adults and infection control.

People's care records did not demonstrate that people had been supported to make best interest decisions in accordance with the Mental Capacity Act 2005.

Staff felt supported and a new system of formal staff supervision was being introduced.

People told us they liked the meals provided and had a choice of foods. There was an emphasis on healthy, well balanced meals yet those people at risk of malnutrition and dehydration were not effectively supported.

Is the service caring?

Inadequate

The service was not always caring.

Not all staff showed a caring approach to people. There was little interaction and some staff spoke to each other rather than to people who used the service. There was an emphasis on tasks rather than person centred care.

People were encouraged to make choices and staff involved people in interventions such as using the hoist. There were positive interactions with people and some staff.

Is the service responsive?

Inadequate

The service was not responsive.

People's needs were not always adequately assessed and care plans did not clearly evidence the support people needed. Proper interventions were not in place to ensure each person's wound and skin pressure area care was managed effectively.

Summary of findings

People told us they would tell a member of staff if they were not happy about the service they received. A record of formal complaints was maintained, which showed issues were dealt with appropriately.

Is the service well-led?

Inadequate 

The service was not well led.

The registered manager was aware that the service was not operating at it should and said they were committed to making the changes required.

Whilst there were comprehensive arrangements in place to monitor the safety of the environment, quality auditing systems were not effective and not identifying shortfalls in the service.

People's views were gained on an informal basis but not regularly documented. People had been sent surveys to give their feedback about the service they received.

Church View Nursing Home

Detailed findings

Background to this inspection

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

This inspection was unannounced on the 11 May 2015. The inspection continued on 12 and 15 May 2015. The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We spoke with 12 people living at Church View Nursing Home and three visitors about their views on the quality of the care and support being provided. We spoke with the registered manager, a senior manager, the clinical lead, care staff and the chef. We looked at people's care records and documentation in relation to the management of the home. This included staff training and recruitment records and quality auditing processes. We looked around the premises and observed interactions between staff and people who used the service.

Before our inspection, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. As this inspection was brought forward in time due to information of concern we had received, the registered manager was not asked to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Inadequate

Is the service safe?

Our findings

There were not enough staff available to meet people's needs effectively. During our inspection the home was busy and call bells were ringing regularly. One member of staff told us "it's always like this. In fact, today has been quite quiet. This is a good day. It's always very busy here". Staff answered the call bells quickly without delay. However, people were not consistently given the time they needed. One person repeatedly used their call bell. A member of staff told us "they do this when they get anxious". Staff did not give the person time or engage them in any activity. Another person needed assistance to use the bathroom. A member of staff told us the person needed two staff because of their mobility needs. They could not locate a second member of staff, which meant the person had to wait for assistance. The staff member told us "it's difficult if there are only three staff on the floor, as you're not paired up with anyone. The majority of people need the assistance of two staff so if you're on your own, you're restricted in what you can do and people have to wait". On another occasion, a member of staff quickly answered a person's call bell. The person wanted to use the bathroom and the staff member responded by saying "I will get the girls". Staff had not returned 10 minutes later.

There were six care staff, two registered nurses, a team leader and a clinical lead on duty. The staffing allocation records showed that staffing levels sometimes reduced to four care staff, two registered nurses and a team leader. Staff told us that 23 of the 29 people living at the home required two staff to assist them with their personal care and/or moving safely. This gave high ratios of people to staff which indicated staffing levels were insufficient and gave little flexibility. A senior manager and the registered manager disagreed with this level of dependency, as described by staff. They said they used a dependency tool to establish the required numbers of staff on duty. The senior manager said another care staff member would be deployed, when occupancy increased to 31 people. The senior manager and the registered manager told us staffing levels were adequate to meet people's needs. They explained that current issues appeared to be skill based rather than not having enough staff available.

Some staff told us staffing levels were generally sufficient to meet people's needs. They said this was because they worked well as a team and if they finished their work allocation, they would help other staff with theirs. One member of staff told us "we work as a team to get everything done. Sometimes if they've finished downstairs, they will come up and help us up here and vice versa". Another member of staff told us "we get everything done as we work hard and want the best for people but sometimes it isn't easy. Staffing can be an issue".

Other staff were less positive about staffing levels. One member of staff told us "sometimes it's so busy, they're just not enough of us to give good care. It upsets me that we can't give people what they need". Another member of staff told us "I'm not going to lie to you. Sometimes it can be really busy and we could do with more staff. Sometimes people's turns could be half an hour late by the time we get to them". Another member of staff said "I know every home could do with more staff but if we had just one extra, we could give people more quality time". The member of staff continued to say "sometimes we go from one person to another without the time to spend just talking to people or giving reassurance. Our minds are on the time and getting to the next person". Another member of staff told us they felt staffing levels were adequate, if all staff undertook what was needed. They told us "if the night staff get so many people up, that helps the day staff as some people are already ready and have been washed and dressed". This view indicated there were not enough staff, which compromised person centred care.

People gave us varying views about the numbers of staff available to assist them. One person said "I've not got any problems. They come quickly if I ever need them". Another person told us "they come quickly. They're very good. It's not something I have a problem with". Other people told us there were occasions when they had to wait for staff to answer their call bell. This was particularly so in the mornings and at night. One person told us "they're so busy but they do their best. They come to you when they can". Another person said "there's often a lot of people ringing and wanting help. Sometimes they ask me if they can leave me to answer a bell. They say they'll be straight back and they are. I don't mind". Two people told us that at certain times, they had to wait to use the commode. Another person said "If I call [to be helped to the toilet], I sometimes have to wait and I do get uncomfortable". A relative told us "the waiting time varies [when using the call bell.]"

Inadequate

Is the service safe?

This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The local pharmacy had undertaken a recent advisory visit to check the management of medicines. The shortfalls identified within this visit, formed part of the registered manager's action plan to improve the service. Despite being identified in the audit, there continued to be gaps in the signing of the medicine administration records. This did not give an accurate account of the medicine's administration or enable the effectiveness of the medicines to be monitored. There had been one recent medicine error. This involved eye drops being given to the wrong person. Staff told us the error had been discussed with the GP but no ill effects were noted. Staff told us only staff trained to do so, administered people's medicines. They said managers were in the process of reviewing staff's competence, so that people's safety with medicines could be enhanced.

Some medicines were prescribed to be taken 'as required'. There were no protocols in place to ensure these medicines were taken in accordance with the prescriber's instructions. Staff told us they were aware of this shortfall and would devise the protocols, as soon as possible. They told us they were aiming to renew all documentation, as the medicines file was showing its age and becoming untidy. They said improvements had been made to the specific storage and administration requirements of some medicines. Staff told us that whilst homely remedies were occasionally used, written authorisation had not been gained from the GP. This did not clarify if the medicines were safe for people to take. A senior member of staff told us they would address this at the same time as devising the 'as required' protocols.

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

There were detailed risk assessments in place which related to the environment and tasks staff were to complete. However, not all risks to people's safety had been identified and properly addressed. This included people's risk of malnutrition, dehydration and pressure ulceration. The registered manager had identified that risk assessments required improvement and this formed part of the home's action plan. One person had an assessment which identified they were at risk of developing pressure ulceration. The assessment had not been updated when the person's health had changed. This meant that the care they were receiving had not been sufficient for their level of need. Another person had been assessed at very high risk of developing pressure ulceration. However, their care plan which was dated the day after the assessment showed a lower risk. This conflict of information placed the person at risk of care which was inappropriate.

During the inspection, we witnessed that one person was moved using a stand aid hoist. Whilst the hoist was in operation, the sling moved to the person's under arms, placing pressure and pulling their shoulders upwards. The person told staff they were hurting them. Staff did not stop the manoeuvre or give any reassurance or show concern. They told the person it was the hoist, which had caused the discomfort. We informed a senior manager of the incident and advised them that the person's manual handling needs should be reviewed without delay.

People told us they felt safe. One person told us "Yes I feel safe here. There's a lock on the front door so only people who need to be here, can come in". Another person said "having staff around makes me feel safe. I don't usually need them but if I do, I know they're here and I just need to call them".

Staff told us they would immediately report any suspicion or allegation of abuse to the registered manager or the most senior member of staff on duty. One member of staff told us they had been asked in their last supervision session, if they were aware of any poor practice or safeguarding issues which needed to be raised. They said the senior staff were approachable so they would have no hesitation in raising any concerns, if need be. The member of staff told us they were confident that any issues would be addressed appropriately. Staff told us they had undertaken training in safeguarding people in the past and when they started employment at the home. The training matrix did not show people were up to date with this training. The registered manager told us this was in the process of being addressed.

Robust recruitment procedures were in place, which ensured people were supported by staff with the appropriate experience and character. All applicants were subject to a formal interview and their previous employers were contacted to provide details about their past performance and behaviour. Applicants provided evidence of his or her identify and their right, if applicable to work in

Inadequate

Is the service safe?

the United Kingdom. Disclosure and Barring Service (DBS) checks were undertaken. A DBS check allows employers to check whether the applicant has any convictions or whether they have been barred from working with vulnerable people.

Inadequate

Is the service effective?

Our findings

Staff training was identified on the action plan, which the registered manager had devised to improve the service. The information indicated that staff training had taken place but training records were not accurate. The records therefore, did not show whether staff had received the training they required, to do their job safely and effectively. The action plan indicated that discussions were to take place with staff about their training needs so that records could be accurately updated. In addition, any requests for training were to be organised. The registered manager told us these actions were underway. A training matrix had been developed, which was colour coded to show all training staff had completed and any areas, which were out of date.

The registered manager told us the organisation produced booklets on certain subjects which would have been given to staff when they started employment at the home. However, the training matrix showed that out of 49 staff, 4 staff had not completed manual handling training and 8 staff required updated, refresher training. 15 staff had not completed updated infection control training and only 10 staff had completed training in safeguarding adults within the last three years. The registered manager told us these areas had been identified as requiring attention and would be targeted next. They confirmed that due to the number of people with pressure ulceration, all staff had recently completed training in this area. They said staff were also in the process of completing 'in house' dementia care training.

The training matrix showed there had not been any training in topics associated with older age or specific health care conditions. This included palliative care, nutrition and hydration and health care conditions such as Parkinson's disease or stroke. Registered nurses had not received up to date training in relation to their clinical skills. This included tissue viability and wound care, catheterisation, venepuncture (taking blood) and syringe drivers (used for pain management during end of life care).

This was a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they felt supported and valued. They said they received good support from each other and from managers. One member of staff told us support was particularly apparent when they were providing end of life care. They said they received formal supervision from the registered manager. This enabled them to talk about their role, performance and any concerns they had. Staff told us they did not feel they had to wait for their next supervision session but could raise issues at any time. The registered manager told us they had supervised each member of staff individually during January 2015. They said they were in the process of introducing a new system of supervision, which was related to teams.

A staff meeting in December 2014 was cancelled, as a high number of staff had other commitments and could not attend. A meeting for registered nurses was held on 13 March 2015. Other staff meetings had not been undertaken. The registered manager was aware that the frequency of staff meetings would benefit from improvement. They said they would ensure this happened although explained they were usually readily available due to being 'on the floor' and could be spoken to at any time. The registered manager confirmed that information was shared with staff during handovers at the changeover of each shift. Staff confirmed this and said the handovers were invaluable to ensure they were up to date with people's needs.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are an amendment to the Mental Capacity Act 2005, which allow the use of restraint or restrictions but only if they are in the person's best interest. Staff were aware of encouraging people to be involved with making day to day choices and decisions. This included people choosing what they wanted to wear and what they wanted to eat. However, there was no evidence of consent or people's capacity to make decisions within their electronic records. The registered manager told us these were kept separately in the nursing stations. Records showed that people's family were to take responsibility for making decisions on the person's behalf but without the powers to do so in the form of a Lasting Power of Attorney, this practice was not lawful.

Within the registered manager's action plan to develop the service, mental capacity and DoLS had been identified as an area which required improvement. The training matrix showed that only two members of staff, a maintenance

person and a member of the care staff had undertaken up to date training in mental capacity. Thirty one staff including the registered manager had not undertaken any training in this area.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not all people at risk of malnutrition had been effectively assessed, monitored and reviewed. One person had been assessed as having low risk of malnutrition but not had been assessed again until three months later. Their gradual decline in weight had not been identified. The person's care plan identified dietary requirements but staff were not aware of these. The person's food chart showed they had only eaten minimal amounts of food each day. There were no further entries of alternative foods or regular attempts to encourage the person to eat, as detailed within their care plan.

Those people who ate limited amounts were not offered alternatives. Food charts did not show that foods or snacks were offered on a frequent basis between meals. Care plans did not identify details of favourite foods, which could be used to promote people's food intake.

Staff asked another person who was in bed, if they wanted a cup of tea. They said they would help the person to sit up and would help them with their drink. The member of staff commented "Oh, you are thirsty" but the person then started coughing and said "no more". The member of staff had been with the person for 1minute 30 seconds. This did not enable the person sufficient time to drink effectively or to have quality interactions with the staff member. Another member of staff helped a person drink their tea. They did this quickly with little conversation other than commenting "you were thirsty".

Charts used to monitor people's fluid intake had not been consistently completed. Not all amounts had been totalled on a daily basis, which demonstrated people's fluid intake was not being effectively monitored. Where daily fluid intake had been calculated, low intake was noted. There was no evidence that additional fluids had been offered to people, to address this.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The chef told us the menus ensured a balanced diet and included people's preferences. They said meals were adapted to incorporate people's health care needs. This included low sugar foods, pureed diets and fortified foods with added cream, full fat milk and cheese, to enhance calorie intake. The chef told us they served all pureed foods separately on the plate, so that people could clearly see and taste what they were eating. They said they tried to ensure variety for those people who preferred a particular diet such as vegetarian food. The chef recognised the importance of food and its value regarding ensuring good health. They said they welcomed comments about meal provision and always aimed to provide alternatives, if a person did not like what was on the menu. They said meals were cooked "from scratch" with regular deliveries of fresh produce.

People told us they liked the food and were offered a choice for all meals. They said there was always plenty to eat. One person told us "the food is very good here. It's what I would have eaten at home. Good traditional food, nothing fancy". Another person told us "the food's excellent. There's variety and lots of it, too much at times". One relative told us their family member did not like fish and so on Fridays they had egg and chips, which they really enjoyed. Their family member was also unable to eat bread, so they had soup or scrambled egg in the evenings, instead of sandwiches.

People said they were able to see a GP if they needed one and saw the chiropodist and the hairdresser regularly. Three relatives confirmed this and said staff kept them informed if their family member was unwell. One person told us they had recently been seen by the GP because of a pain in their shoulder. They said they were happy with the outcome of the visit. Staff told us a GP visited the home on a weekly basis to review people's health care needs. Staff said that in between these visits, GPs were available for advice and would visit if requested.

Inadequate

Is the service caring?

Our findings

Not all staff showed a caring approach to people. At lunch time, staff placed meals in front of people without explaining the content or asking if they needed any assistance. Staff did not make pleasantries such as asking people if they were happy with their meal or if they needed anything. Not all staff smiled at people or displayed warmth within their interactions. Staff did not interact with people whilst assisting them to eat. They loaded the person's spoon and called their name whilst placing the spoon to their mouth. They did not tell people what they were eating or ask people what they wanted to eat next. There was silence with no discussion about topics such as the weather, family or news events. One person sitting at the dining room table indicated that they did not want any more of their lunch. A staff member said "you finished?" whilst moving the plate. There was no further discussion. The person was not asked if they felt unwell or if they had a problem with their meal.

Not all staff promoted people's dignity. Staff called out to each other in the corridors and across the dining room. They talked about tasks and there were discussions about how much particular people had eaten. One member of staff asked "is that everyone done now? I'll go and do X". There was almost no conversation between people and staff. The file which contained information about people's food intake was placed on the dining room table, next to where people were eating their lunch. A number of staff repeatedly made entries in the record, which interrupted people's meal. A senior manager told us this had been identified and the file had been moved from the area to minimise disruption.

One member of staff went into a person's room to answer their call bell. The interaction with the person was polite and friendly. However, another staff member entered the room without knocking or acknowledging the person and began talking to the staff member about someone else. The conversation included details of a personal nature, including the name of the person. Both members of staff then left the room whilst continuing their discussion. There were no further interactions with the person.

One person told us about the care they received. They said "I feel it's all very personal. When they come in, they talk to me about this and that. It's all very pleasant". Another person told us "the carers vary, some are very good and some a bit miserable, but they're all polite on the whole". They continued to tell us "some take a bit more time, others just want to get the job done and go". Another person told us the carers "can be very abrupt". The registered manager told us they were aware that some staff did not appear happy in their work and this sometimes showed. They said this was being addressed. A senior manager told us they believed some staff were very new to their role and had not had the length of time to get to know people well. They felt this impacted on the quality of interactions as the staff were not quite sure, what to talk about. The registered manager told us they were going to work on people's life histories to assist staff in this area.

There were other interactions which were more positive. One person told us they were uncomfortable in bed. We used the person's call bell to summon staff assistance. A staff member responded quickly. They leant over the person, held their hand and asked the person what was wrong in a quiet, concerning manner. They said they would try to make the person more comfortable and closed the door before doing so. Another member of staff answered a call bell and said "Hello X, you look nice. What can we do for you?"

Staff involved people in interventions. They encouraged people to keep their elbows in whilst being assisted to move from one place to another in their wheelchair. Staff asked people to lift their arms so that the hoist sling could be placed underneath them. They informed people of the transfer whilst using the hoist such as "you're going up" and "you're going down, there's the chair". However, there was little other interaction or conversation undertaken.

People told us they were able to make choices about their daily routines. This included what time they got up and went to bed. One person told us "there are no restrictions here. You do what you like and what you would do if you were at home. There's no pressure to do anything you do not want to do". Another person told us "they [the care staff] know when football is on, that's it. I don't go to bed until it's over. They accommodate that". Relatives told us they could visit their family member whenever they wanted to. However, one relative told us that on Mother's Day this year, their family member had a temperature and chest infection. They said "the home rang our brother and said it would be best if we didn't visit mum that day, but without really explaining why. We decided to come still, it was Mother's Day, and mum was glad to see us".

Inadequate

Is the service caring?

Staff told us they aimed to promote people's rights such as privacy and dignity, at all times. They said they always knocked on people's bedroom doors before entering and ensured all personal care was delivered in private with curtains and doors closed. One member of staff told us they covered people when supporting them with their intimate personal care. They said they tried to complete the task as quickly as possible without rushing in order to promote people's dignity but also to ensure they did not get cold. One member of staff told us how they called people by their preferred name as a form of respect. They said "sometimes a person might get called by their Christian name but for me, if I was initially introduced to them by their title and surname that stays. It would seem wrong and too familiar to call them by their first name or a nickname".

Inadequate

Is the service responsive?

Our findings

Staff were not consistently responsive to people's needs. One person was restless and calling out "pick me up, pick me up now." We alerted two members of staff to this person's agitation. One member of staff responded by saying "Oh yes, she does that." Neither member of staff went to the person to offer support or reassurance.

Five people had developed a pressure ulcer whilst being at the home. A safeguarding alert had been made in relation to these people and a large scale investigation was taking place.

We looked at the care records of three people with grade 4 pressure ulceration. The records did not demonstrate that people had been given the appropriate care to ensure healthy skin or to prevent further deterioration to their wounds.

On their admission to the home, one person was assessed as being at high risk of developing pressure ulceration. There was information from the person's previous placement and a discharge plan but no information was recorded on the home's electronic system until six days into their admission. This lack of written guidance did not ensure staff had the required information to support the person effectively. The care plan stated that the person required assistance to change their position at least three hourly and for them to have bed rest during the afternoon. Care charts showed that this support was not given. This impacted on the condition of the person's skin and indicated that staff had not provided the person with the care they required, as detailed in their care plan. The Tissue Viability Nurse was notified of the person's wound and advised that the person was repositioned two hourly. This was not updated in the person's care plan so the instruction to staff was not clear. This increased the risk of inappropriate care.

There were details of the dressings to be used to treat the wounds but no frequency of the dressing regime. Within a different section of the person's records, it was noted that the Tissue Viability Nurse had advised that the dressing was changed every time the person's continence aid was changed. From the date of this advice, there were six days when the wound dressing had not been changed. Written entries within the dressing record lacked detail. This did not enable accurate treatment or monitoring of the progress of the wound, including its size and grade. Within some entries, an odour was noted, which indicated the wound had deteriorated. A swab of the area was not taken until four days later. This delay compromised the person's health and welfare.

Another person's records showed similar shortfalls in their care. A member of the management team told us written records of the person's wound were not maintained. In March 2015, significant deterioration was noted in the wound. An action plan stated the person was to be nursed on a pressure relieving mattress and turned every three hours when in bed. A dressing was applied, a swab taken and a referral to the Tissue Viability Nurse was made. There was no description of the wound to clarify the wound's detail or to monitor progress. The type of dressing used to treat the wound was stated but it was recorded "to be applied as necessary". This did not give staff specific guidance on the wound's management, which increased the risk of inappropriate care. Over an eleven day period in March 2015, there were three days, when the person's care charts were not available. None of the other charts in place for this period, evidenced that three hourly turns, or changes of position, had been carried out. This indicated that the person spent long periods of time sitting in the lounge and that when in bed, turns were infrequent.

During a further consultation, the Tissue Viability Nurse advised that the person received increased support with their repositioning and their wound was redressed daily. Records of the dressing were recorded in different sections of the care plan and within the daily records. This did not ensure consistency and accurate monitoring of the wound. The wound was not dressed on a daily basis and records did not provide details of the wound. There were periods when the person was not supported to change their position, as recommended by the Tissue Viability Nurse. The records showed the person remained in the same position for periods of five, seven or eight hours. This significantly impacted on the person's pressure damage.

The person's care plan indicated they needed to be nursed on a specialised mattress, which was to be checked on a daily basis to ensure it was in good working order. The mattress was in place but the record to monitor it was only started on 6 April 2015. Before this, nothing was recorded. The record showed that from when the record was introduced, there were six days when the mattress was not checked. This meant that staff would not have identified if

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the mattress had failed, which would have significantly impacted on the person's wellbeing. The Tissue Viability Nurse visited on one occasion when the person had just been changed and repositioned. There was concern that the dressing was not complete and there was evidence of contamination under the dressing. This suggested that the person's dressing had been incomplete and soiled when their position had been changed, but no action had been taken by the staff who carried out these interventions.

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

People's care plans were located on a computerised system. The information was held in various sections and was not easy to locate. The care plans were not person centred and lacked detail. One care plan identified that a person required thickener for their drinks to minimise their risk of aspiration. There was no detail about the required consistency of the fluids. A senior manager told us this information was located within a letter from the Speech and Language Therapist in a different section, on the system. This information could easily have been missed by staff, which presented a risk to the person's safety. The registered manager told us care planning had already been identified as an area which required improvement. They said the lack of detail and the terminology used within the care plans would be addressed. The registered manager's action plan indicated that all care plans would be renewed, with four already completed.

People told us they would tell a member of staff if they were not happy with the service they received. One person told us they would speak to the manager. The complaints procedure formed part of the welcome pack which was given to people when they first moved in to the home. One complaint procedure in a person's bedroom gave details of the home's previous manager so it had not been updated. Details about how to make a complaint, were displayed in the entrance area of the home. The registered manager told us they would address this. A record of complaints was in place. This showed that actions had been taken in a timely manner, to resolve issues. The registered manager told us they tried to address issues as soon as possible so they did not escalate into formal complaints. They said they were confident that people's relatives would raise any concerns openly rather than worry about things without saying.

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Our findings

Audits had not been undertaken to identify shortfalls in provision and to monitor the quality of the service. In May 2015, there had been an audit of the medicine administration systems and of infection control. No previous auditing had taken place. Both audits had highlighted shortfalls but there were no action plans to identify how improvements would be made. A member of the management team told us that as the audits had only recently been undertaken, there had not been time to discuss the actions required with the registered manager. They said they were in the process of doing this.

Prior to April 2015, the registered manager had not been submitting monthly management reports as required by senior management. This meant that accidents and incidents such as falls and pressure ulceration were not being identified, evaluated or reported on effectively. The registered manager had not been aware of the severity of people's pressure ulceration. A series of events related to people's pressure ulceration had been coordinated but an investigation which identified outcomes and conclusions had not been undertaken. Whilst accident analysis was incorporated into the monthly manager's reports, this had not been completed prior to April 2015. This meant that possible trends or triggers, to minimise further occurrences had not been identified. The registered manager told us that not undertaking the management reports had mainly been due to staffing issues. They said they had been required to 'work on the floor' to cover staff absences, which had impacted on the time available for management responsibilities. The registered manager told us they had learnt from experience and were now giving priority to this area of their work.

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

The maintenance person had a detailed and comprehensive system to monitor the safety of the environment and the equipment used within the home. There were detailed records which showed various checks, which were undertaken at specific frequencies. This included daily, weekly, monthly, three monthly and six monthly monitoring checks. All areas such as cleaning shower heads to minimise the risk of legionella, monitoring the hot water to ensure safe temperatures and checking the call bell system to ensure it was in good working order, were undertaken. A daily walk around was undertaken to identify and address any potential hazards and to pick up litter. Beds, bed rails and mattresses were checked to ensure they were safe and well maintained. There were a range of fire safety checks and an up to date fire risk assessment in place. Clear procedures identified the responsibilities of staff in the event of an emergency. There was a contact list regarding all utilities which identified key people to contact if required.

The registered manager told us surveys had been sent to people and their relatives to gain their views about the service provided. The surveys had not been evaluated, as the registered manager said they were still waiting for more to be returned. The registered manager told us they had held a 'resident and relative meeting' but attendance had been poor. They said that due to this, they were looking at ways to improve the feedback received about the service. A senior manager told us that whilst attendance at meetings was poor, relatives were confident in raising any issues as they arose. The registered manager said they had an open door policy and were readily available due to being 'out on the floor' regularly. Discussions, where concerns had been resolved, had not been documented. This meant there was no evidence to show how people's views were used to develop the service.

The registered manager had worked at Church View Nursing Home since November 2014. They said when they applied for the post, they were aware that the home was not operating, as they wanted it to. The registered manager told us staff had experienced a period of instability due to repeated changes in management. They believed this had impacted upon clear leadership, direction and vision, which had subsequently affected the service. The registered manager told us they had developed an action plan to address shortfalls, which they had identified since being in post. The registered manager shared this with us. The action plan identified planned improvements to care planning, risk assessments, recording, staff training and medicine management. They confirmed that actions were underway although recognised it would take time to get the home, where they wanted it. They said they wanted Church View Nursing Home "to be the best and to provide excellent, outstanding person centred care". The registered manager told us "it might take time but we will get there".

The registered manager told us they were well supported by senior managers and kept themselves up to date by

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various meetings, reading care journals and researching topics on the internet. They told us they had a good team although they recognised that some staff did not appear happy in their work and were not performing, as well as they were expected to. They said this would be addressed by using formal processes such as the capability and disciplinary procedures. The registered manager confirmed that these procedures had already been instigated in response to an allegation of a person lying in soiled bedding. Another member of staff had been dismissed for sleeping whilst on waking night duty. Following our inspection, the registered manager told us a meeting with senior managers had been arranged and a voluntary embargo had been placed on the home. This meant that there would be no further admissions until improvements to the home had been made. The registered manager told us this would give them time to "sort everything out" and whilst they said were disappointed with the outcome of our inspection, they said "we have a clear baseline to work from and will turn things around".

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **There was no evidence of consent or people's capacity to make decisions within their records. Assessments did not demonstrate best interest decisions, which had been made.**

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements 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 Planning and delivery of care was not always done in such a way to meet people's individual needs and ensure their safety and welfare. Proper interventions were not in place to ensure each person's wound and skin pressure area care was managed effectively. This impacted on people's welfare and safety. Staff had not consistently completed the medicine administration records, to show they had administered people's medicines as prescribed. Protocols were not in place for medicines to be taken 'as required'.

The enforcement action we took:
We issued a warning notice in relation to breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs Not all people's risk of malnutrition had been effectively assessed, monitored and addressed. Appropriate measures were not in place to increase the frequency of foods to these people or their calorie intake. Care plans did not identify details of favourite foods, which could be used to enhance the amount of food eaten.

The enforcement action we took:
We issued a warning notice in relation to breaches of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Whilst there were comprehensive arrangements in place to monitor the safety of the environment and equipment, quality auditing systems were not effective

This section is primarily information for the provider

Enforcement actions

and not identifying shortfalls in the service. Monthly auditing and management reports to senior managers had not been undertaken so shortfalls were not being identified, monitored or addressed.

The enforcement action we took:
We issued a warning notice in relation to breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not enough staff available to meet people's needs effectively. Whilst call bells were answered quickly, not all people were given the time they required and were kept waiting for assistance. Staff commented that inadequate numbers of staff on duty, impacted on the quality of care they could give. Not all staff were up to date with their training in key areas such as safeguarding people and infection control. Other than the prevention of pressure ulceration and dementia care, staff had not received training in topics associated with older age or specific health care conditions. Registered nurses had not received training to update their clinical skills.

The enforcement action we took:
We issued a warning notice in relation to breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.