Koinonia Christian Care

Koinonia Christian Care

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Koinonia Christian Care is a 'care home'. The home accommodates up to 39 older people with dementia or age-related physical frailties across five adapted buildings. The service is a care home which supports people with Christian beliefs. At the time of the inspection there were 30 people living at the service.

People's experience of using this service and what we found
Quality assurance processes were not routinely completed to ensure effective provider oversight of the running of the service. Analyses of incidents and accidents had not been carried out to establish risks, trends and patterns to allow continual learning to improve care.

People's health risks were not always appropriately assessed, care plans were inconsistent and out of date to guide staff on how to meet people's needs. This included providing safe support with swallowing difficulties, weight loss and catheter care.

People were not always supported by enough staff. Staff deployment meant some people with higher needs were not supported in a timely way. We saw where people required assistance at mealtimes, there were not enough staff in the unit to support them. The registered manager covered shortfalls on the rota. People told us they were aware of the shortages and told us staff were doing their best.

People were kept well informed of the changes within the service. A new provider was due to take over the running of the service. People and their relatives were able to ask questions in advance of this happening. One relative told us, "It's interesting to see what will happen with the new ownership. It's an independent caring family situation and I hope that doesn't change."

People were kept safe by staff who understood their responsibilities to recognise and report safeguarding concerns. People received their medicines in a person centred and timely way, staff were trained and assessed as competent before administering people's medicines.

People spoke highly of the support they received. People told us they enjoyed the food and the staff were kind the them. Comments included, "The staff are excellent, I am glad I am here. I feel well cared for." And, "It's a lovely place to be, I am happy, I have my friends, my health."

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection

The last rating for this service was requires improvement (published 4 May 2020).

Why we inspected
We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The inspection was prompted in part by notification of a specific incident, following which a person died in hospital after a choking episode at the service. This incident is subject to an investigation. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about the management of risks and governance of the service. This inspection examined those risks.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to assessing and managing risks and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the new provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Koinonia Christian Care

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Koinonia Christian Care is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Koinonia Christian Care is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced. Inspection activity started on 24 March 2022 and ended on 29 March 2022. We visited the location's service on 24 March 2022.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with six people who used the service about their experience of the care provided. We spoke with seven members of staff including the nominated individual, registered manager, senior care workers, care workers, kitchen assistant and the administrator. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with the operations manager of the new provider.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service were reviewed.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at policies and procedures and care documentation. We spoke with four relatives of people who use the service, four staff members including care workers and the chef.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

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

● Prior to this inspection, we received information of concern regarding a serious choking incident. Risks to people were not always identified and managed safely. Where assessments identified risks, care documents were not always sufficient to guide staff to support people safely.

● The provider had not learned lessons following the choking incident. Where people were at risk of choking due to swallowing difficulties, professional advice had been given by the speech and language therapists (SaLT). SaLT advice had not been clearly updated in the care planning system which provided conflicting guidance to staff. Where people required a modified diet, there were inconstancies in the care records and International Dysphagia Diet Standardisation Initiative (IDDSI) standards had not been followed. IDDSI is a nationally recognised standard for care staff to understand what consistency food and drinks should be prepared to minimise risks of choking. One person was assessed to receive a diet prepared to IDDSI level four 'pureed' consistency, their care records advised staff to prepare to level seven 'regular easy to chew' but further advice stated to prepare to level one which is not an assessed level for food. We viewed five further care records for people at risk of choking, all of which contained similar conflicting advice.

● One person had an assessed IDDSI diet of level six 'soft and bite-sized', however, this was not being followed as the person wished to eat a regular diet. The registered manager told us SaLT said the person could eat what they wished as they had mental capacity to decide, there was no record of this conversation. Without robust risk assessments and care plans, people could not be assured of receiving the correct diet and support to reduce the risk of significant harm. Permanent staff knew who required a modified diet and the chef was knowledgeable on people's individual dietary requirements. Following the inspection, the registered manager provided some immediate assurances around people's choking risks being assessed.

● People had not been accurately risk assessed for malnutrition. Staff used the malnutrition universal screening tool (MUST). MUST is a recognised tool which identifies people who are at risk of malnutrition. MUST outcomes guide staff on actions to take when people have experienced unaccounted for weight loss, for example, referrals to dieticians or to monitor food intake. People's weights and MUST scores were not being effectively and consistently monitored. Where unaccounted for weight loss had been identified, there was no guidance of how these risks could be managed. One person had lost 13kg in one month during a hospital stay. Professional advice was for the person to be weighed weekly, this had not been completed and we saw a gap of weight recording of nine weeks. We saw some people were consistently losing weight without staff seeking professional advice, food intake was not being consistently documented so explanations behind weight loss could not always be identified.

● Risks associated to people's health were not always robustly assessed. For example, one person had a catheter in situ. A risk assessment or continence assessment had not been completed to guide staff on how to safely support the person. The person's care plan stated they had a catheter in place but did not highlight

the associated risks of catheters such as the risk of urine infections or when to consult with professionals for complications such as leakages or blockages.

There was a failure to ensure care and treatment was provided in a safe way or risks to people had been mitigated. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Staff were not always deployed appropriately to meet people's everyday care needs. Where some people required support with their meals, assistance was not always offered in a timely way. For example, Gwynne House was an area of the service designed for people living with dementia, four people required assistance with their meal and but there was only one staff member in the area to support them. This left some people receiving cold food, we observed the person who was assisted last did not wish to eat their meal. We saw one staff member working in the unit had gone for their own lunch break during meal service. People in the main dining room were supported by enough staff and were being assisted appropriately.

● The service was experiencing a shortage of permanent care staff, the registered manager regularly covered shortfalls on the rota. The service was actively recruiting for new staff, and agency staff were arranged to cover shortages. Staff told us, "I am looking forward to the changes, hopefully there will be more staff and more support for us." And, "Staff morale is a bit difficult at the moment, this is because of the shortness. I am confident this is going to change soon."

● People were aware of staff shortages, comments included, "We are quite happy, but there is not much going on here." And, "They struggle sometimes but there is always someone to help." A relative told us, "[Person] doesn't say much about the staff, sometimes when they are pushed, they may sometimes hurry my relative a little bit." One staff member told us, "I like working here that although there is staff shortages, we work well as a team and we are helping each other and understand each other, staff are closer now than before."

● Staffing levels were determined by people's needs. The service was a conversion of five adjoining buildings, the layout of the service had not been considered with the deployment of staff. We observed staffing levels in the day appeared adequate, however, staffing levels decreased at night which had not been considered as a risk in the event of an emergency.

● People and their relatives gave positive feedback about the staff. Comments included, "When I have visited, they are polite and courteous and seem nice to the other residents." And, "The staff are excellent."

● Staff were recruited safely. Applications forms were completed appropriately, pre-employment checks such as references and Disclosure and Barring Service (DBS) checks had been obtained prior to staff starting their employment. DBS check provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal

authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Systems and processes to safeguard people from the risk of abuse

● Systems were in place to safeguard people from abuse. People and their relatives told us they felt safe and could to speak to the registered manager if they had any concerns. One relative told us, "I think [person] feels safe there, they feel better than living alone. They are the type of person that raises an issue if they have one."

● Staff received training and demonstrated their knowledge of the safeguarding policy to prevent the risk of abuse to people. Staff understood their role in the prevention and reporting of potential; abuse and told us they would speak to the registered manager if they had any concerns. Staff knew they could contact outside agencies if required. One staff member told us, "If I suspected abuse, I would tell a senior and management. If management did nothing, I can complain to CQC or the police or social services."

● The registered manager understood their obligation to report any safeguarding concerns to the local authority and to CQC.

Using medicines safely

● People received their medicines safely. Staff were trained in medicine administration and their competencies were assessed prior to them being permitted to administer people's medicines.

● People had medicine profile sheets to guide staff on their preferred way of taking their medicines. We observed people being administered their medicines in a timely and person-centred way.

● There were two medicine leads for the service. Auditing and counting of medicines were undertaken, including stock checks and checks on records such as the electronic medication administration records (eMARs).

● Errors and near misses had been dealt with appropriately, for example, one person had been given paracetamol one hour earlier than prescribed. Staff had contacted the person's GP and had monitored for any adverse effects.

● We saw records of best interest decisions for some people who were authorised to have their medicines covertly administered (without their knowledge but within their best interests). Staff had liaised with professionals to make sure this was completed in a lawful way.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

● Arrangements were in place to support people to safely see their friends and family. The service facilitated in house visits for people.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Working in partnership with others

- Managers and staff were not always clear about their roles. The registered manager had been in post for five months, they told us they had received a minimal handover from the previous registered manager. Due to staff shortages, the registered manager had been covering absences on the staff rota and told us they had been unable to complete quality assurance processes.
- Systems and processes for quality monitoring had not been completed for five months. Shortfalls in care documentation had not been identified or addressed which meant professional involvement had not always been sought in a timely way. For example, a professional advised for a person to be assessed by an occupational therapist for some equipment. The referral had been made but had not been followed up. This advice was specified five months prior to the inspection. Without the equipment, the person was restricted as they were unable to sit out in a chair, therefore, spent long periods in bed. This was raised with the registered manager who told us they would follow up the referral.
- Environmental risks in the service had not been highlighted or acted upon. We observed a person's bedroom had trailing wires on the floor and was cluttered. The stairwells had barriers which were easy to push open, there was no rationale to this, they did not prevent people from walking through, yet the barriers remained in place which posed as an unnecessary hazard. A risk assessment had not been completed for the barriers. This was raised at the inspection, the new provider told us they would take actions to address this.
- Processes had failed to identify care records were not complete and up to date. Where people's food and fluid intake were being monitored, we saw multiple gaps in recording. There was no management oversight of people's food and fluid intake to identify these omissions and take appropriate action.
- Incidents and accidents had not been collated or analysed to allow the service to continually learn and improve care. We saw where accidents had occurred; they had been dealt with on an individual basis. There was a lack of management oversight to identify trends or patterns, such as, accidents happening at a particular time of day or in an area of the service allowing lessons to be learned and taken forward.
- The registered manager had failed to consider staff deployment in relation to people's needs. For example, there were enough staff in some areas of the building, but not enough staff in other areas of the building to support people to eat and drink in a timely way.
- The service mostly worked well in partnership with health and social care agencies. People received external professional involvement including, GPs, SaLT, chiropodists and opticians. Advice had been sought but had not always been documented and followed through. For example, a person who was having

difficulty chewing had been seen by a nurse practitioner, with the aim to have a SaLT referral. Advice was to arrange a dental appointment first; this had not been completed.

Managers and staff were not always clear about their roles and understanding regulatory requirements. The provider had not ensured there were adequate systems to assess, monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people and others. This is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff spoke highly of the registered manager, staff told us they recognised the pressures they faced. Comments included, "I feel [registered manager] is having a hard time as they don't have a deputy, we also have less staff due to sicknesses. I think [registered manager] is coping well." And, "The manager is stressed, they haven't stood still, there is lots of papers to be completed." A relative told us, "The manager seems really pleasant, they are helpful but always seem rushed. I understand this will be resolved with the new organisation. I think there is a lot of pressure."
● We observed people were relaxed with staff and management. The registered manager worked closely with people and knew people well. One person told us, "I am happy, [registered manager] is a good manager, they always check we are happy here."
● The registered manager had identified members of the staff team as moving and handling champions. At the time of the inspection the staff members were on a training course to enable them to train and support other staff and demonstrate new techniques when assisting people.
● The service was in a transitional stage at the time of the inspection, a new provider was due to take over the running of the service. During this phase staff from the new provider's head office were spending time in the service. An audit and action plan had been established by the new provider. They had identified some concerns found at the inspection.
● People, staff and relatives were kept informed of the change of provider. Comments included, "I have been kept up to date with the changes, I know there are various hoops. My relative has been told too, they've mentioned it to me." And, "I am looking forward to the changes, hopefully there will be more staff and more support for us. I spoke to [new provider operations manager], I was really stressed, they reassured me there will be changes, they are interviewing more people so we hopefully we will be alright."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The service promoted an inclusive culture for people. People were given opportunities to express their views through meetings and discussions. We saw people had given feedback at 'residents meetings', for example, they wished to have additional opportunities to practice their faith. We saw this had been arranged. The registered manager told us during the COVID-19 global pandemic, they had lead church services for people to ensure their religious needs were met.
● Regular staff meetings were held; various topics were discussed to include a policy of the month and reminders on matters such as infection prevention and control and fire safety. We saw staff were invited to actively participate to openly discuss matters which were resolved at the meetings. One staff member told us, "We have staff meetings every month, we talk about problems and issues or anything regarding the residents. We are able to talk about any issues. It is anything and everything."
● Relatives were invited to meetings either in person or using video technology. They told us this gave them an opportunity to ask questions in an open forum. One relative told us, "I have been kept up to date, we were given letters and we had a face to face meeting with other relatives."
● Relatives told us they were involved in their loved one's care. They confirmed they were kept up to date

with any changes. Comments included, "They are really open with their commination, the manager is very responsive. If we want to know anything we just have to call." And, "They phone me to update me on things. They call me if [person] falls or has a urine infection, I am satisfied with the professional input. I am satisfied they do the very best they can with my relative."

● Where possible, we saw people were involved in the planning of their care. Care plans contained information which was important to the person such as religious needs, significant people and their life stories.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager was aware of their responsibilities under the duty of candour and had acted accordingly when required. The registered manager told us of their obligation to be honest and transparent went things were to go wrong and to provide an apology. We saw examples of where this had been applied.

● Where regulatory requirements had not been completed, the registered manager showed openness throughout the inspection and was honest about the shortfalls identified with the inspection team.

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 The provider had failed to assess the risks to the health and safety of service users of receiving the care or treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.