Care Quality Commission

Coate Water Care Company (Church View Nursing Home) Limited

Church View Nursing Home

Inspection report

Rainer Close
Stratton St Margaret
Swindon
Wiltshire
SN3 4YA
Tel: 01793 820761
Website: www.coatewatercare.co.uk

Date of inspection visit: 6 October 2015
Date of publication: 18/11/2015

Ratings

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

Overall summary

At the comprehensive inspection of this service in May 2015 we identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued the provider with four warning notices and one requirement stating that they must take action. We shared our concerns with the local authority safeguarding and commissioning teams.

This inspection was carried out to assess whether the provider had taken action to meet the four warning notices we issued. We will carry out a further unannounced comprehensive inspection in six months, to assess whether the actions taken in relation to the warning notices have been sustained, to assess whether action has been taken in relation to the requirement and provide an overall quality rating for the service.

This report only covers our findings in relation to the warning notices we issued and we have not changed the ratings since the inspection in May 2015. The overall rating for this service is 'Inadequate' and the service is

Summary of findings

therefore in 'Special measures'. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for The Church View Nursing Home on our website at www.cqc.org.uk.

At this inspection we found that the provider had taken action to address the issues highlighted in the warning notices. However, some areas required further focus.

Work had been undertaken to raise the awareness of pressure damage. Care plans, risk assessments and care charts had been reviewed. The recording of preventative measures such as supporting people to change their position was much improved. However, not all specialised equipment to minimise the risk of pressure ulceration was being properly used. Records showed a more structured approach to the management of wounds although there was some inconsistency in the description and progress of wounds. Staff had not documented the support people received in terms of managing resistance or effective continence care.

Focus had been given to people's risk of malnutrition and dehydration. A new initiative of baking bread had been introduced to increase people's appetite and interest in food. People enjoyed this activity and had gained weight as a result. People's risk of malnutrition had been assessed and their plan of care updated. People received fortified foods and supplements but these were not always fully documented. Records did not show people had consistently been given snacks between meals or an alternative, if they had declined food. Improvements had been made to records showing people's daily fluid intake.

Whilst a review of the staffing arrangements had taken place, the numbers of staff on duty had not been increased. This was because the home was not operating at full occupancy and a review conducted by the registered manager, of people's dependency, had showed staffing levels to be satisfactory. More staff were being recruited to respond to new admissions and to enable greater flexibility with covering staff sickness. During the inspection the home was calm and people did not have to wait for assistance.

Attention had been given to ensure staff had the required knowledge and skills to support people effectively. Staff had completed a variety of training courses and were discussing their work within newly introduced supervision sessions. New staff had positively added to the skill mix of the team.

Audits had been introduced to monitor the quality of the service. Monthly management reports, which were sent to senior management, gave an overview of the service. People, their relatives and staff had been asked for their feedback about the home, by completing questionnaires. Action plans identified any suggestions made and how they were to be implemented.

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

We found that action had been taken to improve safety for people who use the service.

A review of the number of staff required to support people effectively had been undertaken. Changes to the staff team and their deployment had been made. The home was less rushed and people were not waiting for assistance. Recruitment was taking place to enable greater flexibility.

Improvements had been made to the safe administration of medicines. Staff had consistently signed the medicine administration records to show people had taken their medicines. Protocols were in place to ensure "as required" medicines were administered in line with the prescriber's instructions.

We have not changed the rating for this key question from inadequate because to do so requires a full assessment of all the key lines of enquiry for this question. We will complete this assessment during our next planned comprehensive inspection.

Is the service effective?

Inadequate

We found that action had been taken to improve the effectiveness of the service.

A range of training courses had been arranged to equip staff with the knowledge and skills to do their job effectively. Systems to enable staff to discuss their role were being introduced although needed more time to become fully established.

Focus had been given to managing people's risk of malnutrition and dehydration. However, some people's weight was not monitored as stated in their care plan and not all supplements and snacks between meals were fully documented.

We have not changed the rating for this key question from inadequate because to do so requires a full assessment of all the key lines of enquiry for this question. We will complete this assessment during our next planned comprehensive inspection.

Is the service responsive?

Inadequate

We found that action had been taken to improve the support people received in the management of their skin but further improvement was required.

Care documentation had been reviewed and demonstrated the support people required more clearly. People received support to minimise their risk of pressure ulceration but specific equipment was not effectively used and records did not show the effective management of resistance to support or continence care.

We have not changed the rating for this key question from inadequate because to do so requires a full assessment of all the key lines of enquiry for this question. We will complete this assessment during our next planned comprehensive inspection.

Is the service well-led?

Inadequate

We found that action had been taken to improve the management of the service.

Summary of findings

A series of audits had been implemented to monitor the quality of the service. Monthly management reports, which gave an overview of the service, were being completed and sent to senior management.

People, their relatives and staff had been given surveys to share their views about the service. Feedback had been coordinated and displayed in pictorial and written report formats. Action plans were in place to address any suggestions made.

We have not changed the rating for this key question from inadequate because to do so requires a full assessment of all the key lines of enquiry for this question. We will complete this assessment during our next planned comprehensive inspection.

Church View Nursing Home

Detailed findings

Background to this inspection

This focused inspection took place on 6 October 2015 and was unannounced. The inspection was carried out to check improvements to meet legal requirements planned by the provider after our comprehensive inspection on 11, 12 and 15 May 2015 had been made.

We inspected the service against four of the five questions we ask about services: is the service safe, effective, responsive and well led. This was because the service was not meeting some legal requirements in relation to those questions and we issued warning notices following the last comprehensive inspection.

This inspection was carried out by one inspector, a specialist advisor 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 fourteen people living at Church View Nursing Home and five visitors about their views on the quality of the care and support being provided. We spoke with the registered manager and eight staff including registered nurses, care and activity staff, housekeepers 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 quality auditing processes. We looked around the premises and observed interactions between staff and people who used the service.

Inadequate

Is the service safe?

Our findings

At our comprehensive inspection of Church View Nursing Home on 11, 12 and 15 May 2015, there were not enough staff available to meet people's needs. Call bells were ringing regularly and people were waiting for assistance. There were various concerns from people and staff about staff shortages.

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

As a result of the concerns, we issued a warning notice to the provider. The provider wrote to us with the action they were going to take to address the staffing shortfalls. At this inspection, we found the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 18, as described above.

The registered manager told us that since the last inspection, improvements had been made to the safety of the service. Peoples' dependency had been reassessed and discussed with their placing authority. This was to ensure each placement was adequately funded and there was clear information about the level of staff support each person required. The registered manager told us the review of people's dependency had been used to review the home's overall staffing allocation. They said they had assessed that five care staff, a registered nurse and a unit leader on duty each day was sufficient to meet people' needs. This was because the home was not operating at full occupancy. The registered manager told us additional staffing would be deployed when the number of people in the home increased.

There had been changes to the staff team. The registered manager told us some staff had left the home's employment and more staff, which the registered manager described as being "of a higher calibre", had been recruited. They said the new staff had increased the knowledge and skill base of the team, which had in turn, enhanced the service provided to people. In order to develop the responsiveness of staff, the registered manager told us staff were now required to go where people needed them, rather than being allocated to a specific area of the home. Records showed that consideration was being given to the shift patterns of staff to ensure greater capacity, at key times of the day.

The registered manager told us whilst staffing levels were sufficient, there remained a problem with staff sickness. They said this was being addressed but if staff went sick at the last minute, finding agency staff to provide cover was difficult. The registered manager told us that due to this, staffing levels occasionally went lower than preferred. Records showed there were three occasions during one week, when the numbers of care staff on duty reduced to four instead of five. The registered manager told us when this happened, they would work the shift themselves and ancillary staff were called upon, to help out wherever possible. The registered manager told us this situation was not ideal but they were undertaking further recruitment to minimise future occurrences. They told us they were looking to recruit five more full time care staff to enable greater flexibility with the staffing rosters.

People and their relatives told us that since the last inspection, there had been some improvements in the time it took staff to answer the call bells. One person told us "sometimes, we have a long wait for the bell to be answered but it varies. During the day it is much better than it was but at night there is a longer wait". Another person said "I don't have to wait too long before someone comes to help me, but there is the odd occasion when everybody is busy. If you need the toilet it can be a real problem". People's relatives told us "X needs hoisting but when he needs help, he gets it immediately" and "I've had the odd go because call bells weren't being answered but it's much better since". Records showed that one relative had made a complaint about the time it took staff to answer a call bell. The response to the complaint was that the home had not been short staffed but staff were dealing with an emergency. An apology was given to the relative.

Staff told us there were generally enough staff available to meet people's needs. One member of staff said "it's much better. It's not so much that there are more staff, it's that they're used better. It's more organised". Another member of staff told us "oh yes, there are enough of us, its fine. It's busy but not rushed. We get time to do what's needed. I really like it here". Some staff told us whilst staffing levels were satisfactory; an increase would enable them to deliver more person centred care. They said this would involve having more time to sit and talk with people throughout the day. One member of staff told us "we don't have a lot of time to sit with people so I always try and chat to people during their personal care".

Inadequate

Is the service safe?

The atmosphere of the home was calm and staff did not appear rushed. Call bells were ringing but not as frequent, as at the last inspection. People were not kept waiting for assistance. In the afternoon however, staff were difficult to locate as they were either supporting people or on their break. Due to this, one member of staff was called away from serving drinks, to support a person with their personal care. This caused an infection control risk, as well as causing delay in people receiving their drinks.

At our comprehensive inspection of Church View Nursing Home on 11, 12 and 15 May 2015, staff were not appropriately signing the medicine administration records when people had been given their medicines. There were no protocols to ensure people received their 'as required' medicines, as prescribed.

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

As a result of the concerns, we issued a warning notice to the provider. The provider wrote to us with the action they were going to take to address the shortfalls. At this inspection, we found the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 12, as described above.

Improvements had been made to the management of people's medicines. Staff were consistently signing the medicine administration record to demonstrate they had given people their medicines. There were no gaps in the records, which showed people were receiving their medicines, as prescribed. Protocols had been devised for medicines to be taken, 'as required'. All information was clear although one protocol did not give details of when the medicine should be administered in measurable terms. The registered manager told us they would address this with staff, without delay.

Inadequate

Is the service effective?

Our findings

At our comprehensive inspection of Church View Nursing Home on 11, 12 and 15 May 2015, not all staff had received training to do their job effectively and training records were not up to date. Staff had not received regular formal supervision to discuss their work.

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

As a result of the concerns, we issued a warning notice to the provider. The provider wrote to us with the action they were going to take to address the shortfalls. At this inspection we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 18, as described above.

At this inspection, the registered manager told us focus had been given to improving the effectiveness of the service. They said this particularly applied to the provision of staff training so staff had the knowledge and skills to do their job effectively. The registered manager told us all staff had completed up dated training in safeguarding people from harm, pressure ulcer prevention, moving people safely, infection control and the Mental Capacity Act (2015) and Deprivation of Liberty Safeguards. They said new staff had received training in subjects such as moving people safely and safeguarding, as soon as they started their role. The registered manager told us the staff training matrix had been updated. They said it now showed an accurate picture of the training staff had undertaken and those training courses, staff were scheduled to undertake.

Staff told us there had been an improvement in the service since the last inspection. One member of staff told us "staff morale is much better. It's calmer, not so rushed. It's more structured. Staff know what they have to do and they do it. It's much better and still improving. There's been a lot more training so staff's skill base is better". Another member of staff said "there has been an improvement. The paperwork is up to date and there has been more training since the last inspection". Staff told us there was much more attention to detail and they were supporting each other to bring about the changes needed to further improve the service.

One member of staff told us they had recently undertaken dementia care training. They had a clear awareness of those people living with dementia in the home. The member of staff understood triggers that could lead to certain behaviours and described strategies they used to calm and reassure people. Another member of staff told us how a person liked a particular song. They said they began singing it with the person and then gradually lowered their voice until the person took over. They told us "little things like that are so important to people". Staff told us the training had been beneficial in developing the service. They said they discussed their training needs during their supervision sessions. Staff told us that since the last inspection, they had received regular supervision and appraisals, as part of their personal professional development.

There was a schedule, which detailed all staff and their supervisors. The registered manager told us that since the last inspection, all staff had been allocated a supervisor and formal supervision sessions were taking place. This enabled staff to discuss their work and any concerns they might have on a more formal basis. The registered manager told us they were aware that a longer timescale was required to ensure the system was fully embedded and working well.

At our comprehensive inspection of Church View Nursing Home on 11, 12 and 15 May 2015, not all people at risk of malnutrition had been effectively assessed, monitored and reviewed. Those people who ate limited amounts were not offered alternatives and food charts did not show that foods or snacks were offered on a frequent basis between meals.

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

As a result of the concerns, we issued a warning notice to the provider. The provider wrote to us with the action they were going to take to address the shortfalls. At this inspection we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 14, as described above.

Improvements had been made in relation to the management of people's risk of malnutrition although there remained some shortfalls. During the morning, bread was made in the dining room to enable the smell of baking bread to drift around the home. This initiative was introduced to increase people's interest in food and stimulate their appetite. The warm bread was served buttered, in the afternoon. People told us they enjoyed the

bread making. They said as well as eating the bread, it brought back memories of their earlier life. The registered manager told us that since this initiative was introduced, twelve out of twenty three people had gained in weight.

People had been assessed in relation to their risk of malnutrition. Whilst four assessments were undertaken accurately, one assessment had been scored incorrectly. The error identified the person at low risk of malnutrition although they were actually at high risk. Staff immediately addressed this. Records did not show those people at high risk of malnutrition were weighed weekly, as detailed in their care plan. This included one person who had lost weight since being weighed at the beginning of September 2015. There was an instruction that the person was to be referred to a dietician but no evidence this had been undertaken. A registered nurse told us they would address this without delay.

Staff told us that since the last inspection, focus had been given to enhancing some people's weight. The chef was aware of people who required fortified meals. Staff told us some people had supplement drinks or ingredients such as full fat milk, cream and supplement powder, added to their food to increase calorie intake. Whilst this was in use, staff had not consistently recorded on one person's food chart that supplement powder had been used. There was also discrepancy in relation to how much supplement was to be applied. This detail was not recorded in the person's care records.

Staff monitored the daily intake of people who were at risk of malnutrition. The records were more consistently completed than at the last inspection. One member of staff told us many of the people at risk of malnutrition enjoyed high calorie, full fat yoghurts. They said that due to this, large selections of flavours were regularly purchased. The member of staff told us "the home gets through loads, as they're good if you're not really hungry and they're easy to swallow. They're regularly offered to people either as a dessert or a snack". People's records generally showed the yoghurts, as a dessert, not as an extra supplement to enhance calorie intake.

Records did not show that one person who was at risk of malnutrition, had been offered alternatives if they did not like their main meal. Their food chart did not consistently show they were offered snacks between meals. Staff had not recorded what action they had taken in response to the person refusing foods. Other people's records showed they were offered snacks but this was particularly in the evening, not during the day. A member of staff told us they did not know why staff were not recording foods, which were given between meals, such as biscuits with mid-morning coffee. They said they knew staff offered more snacks than what was recorded. The member of staff told us they would address the completion of food charts with the staff team. Discussions were held with those staff on duty, later in the day.

People were offered regular drinks throughout the day and had access to drinks in their room. If a person was at risk of dehydration, their recommended fluid intake was recorded in their records. This gave staff clear guidance about the amount of fluid people needed to promote good health. Fluid charts showed people had been given regular fluids throughout the day. People's fluid had readily improved since the last inspection. However, at 12.10pm on the day of the inspection, one person's record showed their last drink was at 8am. This did not address their risk of dehydration. All fluid charts were totalled and signed by a registered nurse at the end of the day. This practice demonstrated the records were being used as an audit tool to monitor people's hydration.

One person was prescribed thickened fluids to minimise their risk of aspiration. There was discrepancy between staff in relation to how much of the thickener was required. Two staff told us the person had two scoops of the thickener with every 200mls of liquid. The person's care plan stated one scoop was required. The lack of staff awareness created a risk of the person choking and did not ensure the thickener was used, as prescribed. The registered manager told us they had arranged for staff to receive training in nutrition and hydration. They said they were waiting for the dates, before final arrangements could be made.

Inadequate

Is the service responsive?

Our findings

At our comprehensive inspection of Church View Nursing Home on 11, 12 and 15 May 2015, staff were not consistently responsive to people's needs. Five people had developed pressure ulceration and records did not demonstrate that people had been given the appropriate care to ensure healthy skin or to prevent further deterioration to their wounds.

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

As a result of the concerns, we issued a warning notice to the provider. The provider wrote to us with the action they were going to take to address the shortfalls. At this inspection we found the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 12, as described above.

The registered manager told us staff had worked hard at improving the recording systems in relation to people's care. New files had been developed, which contained a series of new formatted care charts. The charts detailed the support people received including changes in position to minimise the risk of pressure ulceration. The registered manager told us they regularly checked to ensure the charts were being completed effectively. They said they used a high-lighter pen to identify any gaps in the recording, which required attention. The registered manager told us that the number of shortfalls identified on the forms was significantly reducing, week by week.

Work had been done to raise awareness of pressure damage. Staff told us they had all recently received some form of training in pressure ulcer prevention. One member of staff was undertaking more in depth training in relation to tissue viability and wound care. Records showed staff had requested specialist tissue viability advice, in a timely manner, as required. This was in relation to one person who had developed pressure ulceration, since the last inspection. The person's care was subject to multi-agency discussion due to their resistance in accepting support. However, the person's records did not show a consistent approach in managing the resistance. One record stated staff should not persist but should return later. Another record stated three staff were at times required to support the person with their personal care. The registered manager told us staff had not been trained in the use of restraint. There was no clear management plan in place. The person's records frequently stated 'declined' or 'aggressive' but there was only one incident form showing the risks to the person or the staff. Records showed details of the person's wound and its treatment but there were no photographs. This did not evidence the progress of the wound.

People had been assessed in relation to their risk of pressure damage. Whilst four assessments were accurate, one was not. This was because the person's recent weight loss had not been taken into account within the assessment. This gave an inaccurate score which identified the person was at lower risk than they actually were. Some assessments indicated they needed to be reviewed in four or five months' time. As people were frail and had complex, changing needs, this frequency was insufficient to minimise the risk of pressure damage.

The registered manager told us all care plans had been updated to show people's needs and the support they required, to ensure healthy skin. Care charts showed the frequency each person at risk of pressure ulceration needed to be repositioned, if they were unable to do this independently. This gave clear guidance to staff about the support each person required. The charts were consistently completed and showed the required support had been given. However, records were inconsistent when evidencing how staff supported those people who were resistant to repositioning. One person told us that once they were assisted into bed, they stayed in the same position all night, as they were unable to reposition themselves. A member of staff told us this person regularly refused assistance with repositioning or returned to their preferred, most comfortable position after receiving support. These factors had not been documented in the person's care records.

Those people at risk of pressure ulceration had appropriate pressure relieving equipment. However, some mattress settings were not in line with the person's weight. This increased the risk of pressure damage and could have a negative impact on the healing ability of any wounds. One person's care plan stated they were to wear a specialised boot to relieve pressure on their foot. On the morning of our inspection, the boot was on the person's bed and they

Inadequate

Is the service responsive?

had their foot placed on a cushion. This did not give the wound protection and placed the wound at risk of further deterioration. In the afternoon, the person was wearing the boot, as detailed in their care plan.

Records showed that wounds were generally responded to in a timely manner, as detailed in the person's care plan. There was a system in place which alerted staff to when the next dressing changes were due. There was some inconsistency regarding the evaluation of the wounds. This included the wound's dimensions, the assessment of the base of the wound and pain assessment. Progress of the wounds was not evidenced by regular photographs. Measuring strips or grids were not used to accurately record the dimensions of wounds.

Some people required assistance with continence care. Records showed the frequency of this was minimal. One record identified a person received support at 12pm and again at 9.05pm. This was insufficient to ensure healthy skin. The registered manager told us this was a recording issue, as they knew people were supported regularly throughout the day. These people were prescribed barrier creams to be applied to their skin after their continence care. Records showed clear direction to ensure the correct application but staff had inconsistently signed to demonstrate they had applied the creams. This presented risks to people's skin integrity.

Inadequate

Is the service well-led?

Our findings

At our comprehensive inspection of Church View Nursing Home on 11, 12 and 15 May 2015, audits had not been undertaken to identify shortfalls in provision and to monitor the quality of the service. Monthly management reports had not been completed and the analysis of accidents and incidents was not taking place.

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

As a result of the concerns, we issued a warning notice to the provider. The provider wrote to us with the action they were going to take to address the shortfalls. At this inspection we found the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 17, as described above.

At this inspection, improvements had been made to the management of the service. Audits in relation to medicines, infection control, the kitchen, care planning and the overall environment had been implemented. Shortfalls were being identified and action plans showed how they were to be addressed. The registered manager told us that due to the recent embargo on admissions, there were a high number of vacancies within the home. As disruption was at a minimum, the registered manager said they had taken the opportunity, to refurbish the empty bedrooms. This included redecoration, new furniture and furnishings of twenty five bedrooms.

The registered manager had consistently completed the monthly management reports, which were sent to the operational manager for monitoring purposes. The reports identified particular issues such as accidents and incidents and the number of complaints and safeguarding referrals, which had been made. Whilst the information had been appropriately completed, further investigation in to the issues was not evident. For example, on each management report, it was stated there were three or four people with urinary tract infections and bacterial infections (MRSA).The reasons for these infections had not been investigated and measures had not taken to minimise further occurrences.

The registered manager told us that since the last inspection, a high level of work had been undertaken to improve the service. They said the home was now more organised, communication and staff morale had improved and there was more attention to detail. They told us it had been an emotional journey, which had not been easy but staff had pulled together to make things better. The registered manager told us they were aware more progress was needed and all improvements had to be embedded and sustained. However, they said they were more positive about the home and the service now provided. The registered manager was complimentary about the staff team. They said they had worked hard to adhere to new systems, at a particularly difficult time.

Staff were positive about the improvements made since the last inspection. They said communication and training were areas, which had made most impact. Staff spoke positively of the registered manager and said they felt well supported. They said teamwork had improved and staff were now a far more cohesive unit.

The registered manager told us that as the embargo on admissions had been lifted, all new people to the service would be introduced slowly. They said the admissions would be on a staggered basis and in the beginning, people with complex needs would not be accepted. The registered manager told us they felt it was important to continue improving the service and embedding practice before occupancy increased significantly.

People, their relatives and staff had been given a survey to provide feedback about the service. The findings had been coordinated and were identified within pictorial formats and a written report.

Action plans had been devised to show how suggestions would be implemented. The registered manager told us people had responded well to the surveys although time was required to implement suggested improvements.