The Churchley Rest Home Limited

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Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on 5 November 2015.

The Churchley Residential Home is located in Hove. It is registered to accommodate a maximum of 18 people. The home provides support to older people who may need assistance with their personal care and support needs. The home is a large detached property, spread over three floors. On the day of our inspection there were 16 people living at the home.

The service provider, Mrs Lewis, also works as the manager. Registered providers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

People's consent was gained before being supported with medication, they were provided with drinks to enable them to take their medication and were happy with the

Summary of findings

support provided. One person told us "They bring my tablets to me in the morning with my breakfast – they are never late." However despite peoples positive experience medicines were not managed safely in accordance with current good practice guidance and regulations. A medication policy was in place, however this hadn't been updated for several years. There were no guidelines on the use of 'when required' medication, staff were unaware of what this meant and which person had pain relief prescribed on an 'as and when required' basis. People who administered their own medication had no assessments in place to assess and mitigate any risks. Medicines were not always stored securely and there were gaps in medication administration records leading to confusion as to whether people had taken their medication or not. Medicines were not always dispensed and administered in a safe manner.

People spoke highly of the registered manager and the leadership within the home, there was an open culture where people, relatives and staff felt able to approach the registered manager if they had any concerns. However people's safety could have been compromised as there were not effective, documented systems to monitor and audit the quality of systems and processes in place around medication administration. Audits ensure that any trends and areas for improvement are identified and used to drive change. This is an area of concern.

People's independence was promoted, their rights were respected and their privacy and dignity maintained. People were able to make their opinions and feelings known on a daily basis, for example people had said that they didn't like one of the menu options, this was listened to and the menu changed. Consent was obtained before people were supported and they were encouraged to make their own decisions. For people that lacked capacity relevant assessments had been undertaken and procedures followed to ensure that restrictions on their freedom complied with legal requirements. However an area of concern is that the registered manager had not informed CQC of these, not being informed of restrictions on people's liberty meant that CQC were not able to assess or ensure that the appropriate actions had been taken to ensure that people were not deprived of their liberty illegally.

People were encouraged to eat and drink nutritious, home-cooked meals, people enjoyed the food and were able to choose alternative options if they didn't like the meals offered. For people who had been assessed as being at risk of malnutrition, effective action had been taken to improve this, however they didn't have their weight or food and fluid intake regularly recorded. Therefore staff lacked oversight as to the person's intake throughout the day and of their weight over a period of time. We have made a recommendation about the monitoring of peoples weights and food and fluid intake.

Organisational policies were not up to date and didn't reflect current legislation, therefore staff were not provided with relevant information in order for them to support people in line with current best practice or legal requirements. This is an area in need of improvement.

People were happy at the home, they felt safe and able to maintain their independence, one person told us "The staff help me when I need it, if they think I'm at risk that is, but other than that I manage alone." Staff that were suitable to work within the health and social care sector were recruited and their employment history and suitability to work in the sector were checked prior to them starting work. Staff received training that ensured that they were able to meet people's needs and ensure their safety and protection from abuse.

Staff had received essential training and there were opportunities for additional training specific to the needs of the people living at the service. Staff had received regular supervision meetings with their manager as well as annual appraisals.

People felt well looked after and supported and we observed positive, warm affection and genuine relationships. One person told us "The staff are all very jolly. It's just like family really." People had their needs assessed and their needs, abilities and preferences were made known to staff as there were care plans in place detailing these.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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?
The service was not consistently safe.

People were able to take risks. However people at risk of malnutrition did not have their weight or food intake recorded on a regular basis.

Not all medicines practices were safe.

Staffing levels ensured people's safety, these were increased in response to people's needs and people felt happy that there was adequate staff available to meet their needs.

Requires improvement

Is the service effective?
The service was effective.

People were cared for by suitably trained staff that had the skills and experience to meet people's needs.

People were asked their consent before staff supported them and measures had been taken to comply with legislation when people lacked capacity to give their consent.

People had access to enough food, they had nutritious well balanced, home-cooked meals that met their needs and preferences.

Healthcare appointments and access to professionals were available to meet people's individual health needs.

Good

Is the service caring?
The service was caring.

People were cared for with compassion and kindness, by friendly staff that they had developed positive relationships with.

People were asked their opinions and involved in decisions affecting their care.

Staff respected people's privacy and dignity and people were treated in a respectful way.

Good

Is the service responsive?
The service was responsive.

People at the service received a service that was responsive to their needs and preferences.

People were able to take part in activities of their choice and were able to choose how to spend their time and fulfil their interests.

Good

Summary of findings

People were actively involved in decisions that affected their care as well as the running of the home and feedback from them was used to improve the service.

Is the service well-led?

Requires improvement

The service was not consistently well-led.

People and staff were positive about the management and culture of the home. However quality assurance processes were not always followed, or used to drive service improvement, audits on the management of medicines had not taken place and errors had not been noticed or acted upon.

People were able to maintain links with the local community through the provision of entertainment provided by external organisations.

People were treated as individuals, their opinions and wishes were taken into consideration in relation to the running of the home.

The Churchley Rest Home Limited

Detailed findings

Background to this inspection

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

The inspection took place on the 5 November 2015 and was unannounced. The inspection team consisted of two inspectors and an inspection manager.

On this occasion we did not ask the provider 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. Before the inspection we checked the information that we held about the service and the service provider. We used this information to decide which areas to focus on during our inspection.

During our inspection we spoke with four people, two visitors, four care staff and the registered manager. We also contacted two health professionals after the inspection. We reviewed a range of records about people's care and how the service was managed. These included the care records for six people, medicine administration record (MAR) sheets, three staff training and support and employment records, quality assurance audits, incident reports and records relating to the management of the service. We observed care and support in the communal lounges and dining areas during the day. We also spent time observing the lunchtime experience people had and the administering of medicines.

The service was last inspected in January 2014 and no areas of concern were noted.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe living at the home. One person told us, "Oh yes, there's no problem there. The staff look after me really well." Another person told us, "The staff help me when I need it, if they think I'm at risk that is, but other than that I manage alone."

The provider had a statement of purpose, this stated 'We believe that people, staff and visitors should be provided with a safe environment which embraces all aspects of their life. This includes being assured that the services provided are appropriate to their care and support needs and that staff employed to care for them will keep them safe'. However, despite the positive comments from people and the homes statement of purpose we found areas of practice that required improvement.

People were supported to take their medication whilst having their lunch, drinks were available to enable people to take their medication and people's consent was gained before assisting them. People told us that they were happy with the support that they received in relation to medication. One person told us "I take a lot of tablets and I don't think I could manage them myself. The staff are very good." Staff responsible for administering medication had received medication management training from a local pharmacist. In addition, competency checks on staff took place on a six monthly basis.

The National Institute for Health and Care Excellence (NICE) quality standards 'Managing Medicines in Care Homes' recommends that care staff should follow the six R's when administering medication. These include – right resident, right medicine, right route, rights dose, right time and a resident's right to refuse. We observed medication being administered to several people at once, which was not in line with this guidance. Medication was dispensed from each person's medication pack, however the information on these packs was not checked to ensure that it corresponded with the Medicine Administration Records (MAR) charts. Instead tablet medicines were dispensed from the lunch time pack to people at the same time. 'Managing Medicines in Care Homes' recommends that care staff administering medication should make a record of administration as soon as possible and complete the administration and recording before moving onto the next resident. However because the medicines were dispensed to each person at once and then the MAR chart updated after this there was a risk that the medication may have been administered and recorded incorrectly. MAR charts showed gaps in recordings, therefore it was unclear if medication had been administered, but not signed to confirm this or if it had been missed altogether. These gaps in the recording of medicines administered had not been recognised by the registered manager as the MAR charts were not audited and this meant that potential errors were not recognised or acted on.

The guidance considers all aspects of managing medicine and recommends that care homes have a medicines policy. It states that the policy should ensure that all processes are in place for safe and effective use of medicines in care homes. A policy was in place, however this had not been updated for several years and did not reflect current good practice guidelines, such as the National Institute for Health and Care Excellence guidelines 2014.

Guidance suggests that helping people to help look after and take their medicines themselves is important in enabling people to retain their independence. Care home staff should assume people are able to look after and manage their own medicines when they move into a care home, unless indicated otherwise. The registered manager had acknowledged this and enabled a person to administer their own medication.

When we spoke to the person they told us "Yes I can manage fine, there's no problem." However we observed that the person's medication was not kept secure, it was stored in an unlocked drawer and on the person's table. Whilst we were speaking to the person another person in a next door room came into the room several times, the person confirmed that this often happens. This person was living with dementia and could potentially have access to the medication, therefore this posed a risk as this had not been risk assessed or managed appropriately. Whilst speaking to the person who self-medicates they informed us that their vision was poor and that they were unable to read newspaper print, therefore this posed a risk to their safety as they were unable to clearly read medication labels. There were no mechanisms in place to establish how many tablets there were in the person's possession, or to record what medication had been taken. Guidance states that an individual risk assessment should be undertaken to determine the levels of support a person needs to manage their own medicines. Within the home's policy it mentioned the procedures that should be followed

Is the service safe?

if a person wishes to administer their own medication. The policy stated that the manager should ensure that the support arrangements were fully documented in the person's care plan and that risk assessments were in place and reviewed. Records showed that there was no assessment in place and therefore risks were not recognised or managed appropriately to ensure the safety and well-being of the person or others.

People's medicines that needed to be stored in the fridge were clearly labelled and were dated when they were opened. Fridge temperatures had been monitored to ensure that the medicines were stored at the correct temperature. However they were not kept secure, medicine was stored in the same fridge as food, and was not isolated from food products, as a result of this medicines were not secure as the fridge was unlocked. Medicines that weren't required to be stored in the fridge were secure and kept in a locked cupboard.

People had been prescribed medicines that they could take as and when they required them. The NICE guidance states that care homes should ensure that a process for administering 'when required' medicines is included in the care homes medicines policy. It states that policies should include clear reasons for giving 'when required' medicine, minimum time between doses if the first dose has not worked, what the medicine is expected to do, how much to give if a variable dose is prescribed, offering the medicines when needed and not just during 'medication rounds' and recording 'when required' medicines in peoples care plans. There were no guidelines for staff to follow in relation to 'as and when required' medicines and therefore staff were not provided with clear guidance to follow in relation to these. This meant that people may not have had access to medicines when they needed them or that they may have been administered in an inconsistent way. The provider did not have a robust, safe process for the safe management of medicines.

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

Risks to people had been assessed, however people had been weighed monthly for the past year, there was no specific risk that had been identified to warrant this and the people's weight had remained largely unchanged over the year. A Malnutrition Universal Screening Tool (MUST) was in place for people who were considered to be at risk of malnutrition. 'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition, or obese. One person who was assessed as being at risk of malnutrition, hadn't been weighed for several months due to being unsteady on her feet, no alternative means of weighing this person to ensure she didn't lose any more weight had been considered therefore there was no evidence of oversight of the person's weight and the increased risk of malnutrition. Another person had lost weight over a period of time, although relevant health professionals had been contacted such as the GP and nutritionist, there was no monitoring or oversight of what the person was eating and drinking on a daily basis. Food and fluid record charts can provide important information that forms the basis of a nutritional assessment and helps determine subsequent treatment plans. The monitoring of food and fluids for people at risk of malnutrition is an area that needs to be improved upon.

People were protected from harm and abuse, staff had undertaken safeguarding adults at risk training. There was a whistleblowing policy in place and staff were able to identify the correct safeguarding procedures they should follow if they suspected abuse. One member of staff told us, "I would let my manager know if I suspected abuse. I'd call you (the Care Quality Commission) if they didn't do anything. I'm sure they would though." Another staff member said, "I just couldn't tolerate it. I've come across it (an abusive situation) at a different home before and I let the CQC know".

Falls can negatively affect people's confidence, reduce their independence and lead to increased isolation. People had been assessed prior to moving into the home to determine the risk of falls, appropriate measures had been put in place if a person was assessed as being at a high risk of falling. These included referrals to the occupational therapist for appropriate mobility equipment.

There were low incidences of accidents and incidents, however those that had occurred had been recorded and monitored. For example the registered manager monitored the frequency of falls for people, if this reached a certain level then a falls risk assessment was completed and relevant action taken as a result. For example in one person's care plan we could see that following this monitoring the person was provided with suitable mobility equipment and a pendant call bell so that they could call

Requires improvement

Is the service safe?

for assistance if they had a fall. People confirmed that they felt safe, one person told us "It's not my own home but I feel safe here. I had quite a few falls before I came in but I haven't had any since I came here."

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular checks in relation to fire safety had been undertaken and people's ability to evacuate the building in the event of a fire had been considered and each person had an individual personal evacuation plan.

People were cared for by staff that were suitable to work within health and social care. Disclosure and Barring Service (DBS) checks had been undertaken prior to employment. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups of people. Staff records also showed that information regarding their employment history and suitability of work had been confirmed.

People felt that there was enough staff to meet their needs, one person told us, "Yes, there are. I don't have to wait for long when I call my bell." Another person told us "They seem to have plenty of time when they are with me. I don't feel rushed." A member of staff confirmed this as they told us "There's plenty of time to spend with the residents. That's one of the things I like about working here." Staffing rotas confirmed that there were adequate numbers of staff to ensure safe and effective care was delivered to people, these were based on people's needs and abilities and the amount of support they required. The registered manager told us that staffing levels were increased when necessary, for example an additional member of staff now worked at the weekends as this had proved a popular time for people to want to go out of the home, therefore there were adequate amounts of staff available to support people to do this if they so wished. When we asked staff for their opinions on the staffing levels one person told us "There are usually three of us on in the day and that's plenty I think." A relative visiting told us "It's a small home but there's always someone about, I don't spend ages trying to find someone if I need to speak to them."

Good

Is the service effective?

Our findings

People we spoke with were happy that staff had sufficient skills and experience to care for them safely. One person told us "I think they know what they are doing. I have a lot of faith in them."

Staff had followed the Skills for Care Common Induction Standards when first starting work at the home, One member of staff told us "I had a really good induction. I shadowed staff for two or three weeks before I worked on my own. It was the best thing really. I learned so much." The registered manager was aware that new recruits would need to complete the Care Certificate to ensure that they were undertaking their induction in accordance with current legislation. Mandatory training was offered to staff, this was updated regularly to ensure that their knowledge and skills were current, it included courses for safeguarding adults at risk, infection control, manual handing, first aid and food hygiene. One member of staff told us "We do the training every year. It gets a bit repetitive but it's important I know." Another member of staff told us "We get updates every year which is good even if you've been here a long time."

Staff had also received training from the dementia in-reach team to help provide them with the necessary knowledge and understanding in relation to supporting people with dementia, staff were able to implement this and following the training were able to introduce activities that people living with dementia might enjoy, they had also labelled rooms and cupboards so that people living with dementia could orientate themselves around the building and find their possessions in their rooms. Most staff had undertaken or were working towards Diplomas in Health and Social Care and records showed that the skills and experiences of staff had been taken into consideration when devising the rotas. The registered manager monitors and assesses staff competence through observations of their practice to see if their practice needs to improve. One relative confirmed this as they told us "The manager runs a tight ship here. If a staff member is out of line or doesn't know what they're doing, they'll know pretty quick."

Staff files showed that staff received supervision every six months and had an annual appraisal. These enabled the staff and registered manager to discuss performance issues and learning and development needs and were a chance for the registered manager to provide feedback to the member of staff. Staff were happy with the supervision and appraisal process. One staff member said, "We get that every six months plus a yearly appraisal." Another staff member told us, "I find it a good thing and I can say what I want. But I know I can speak to my manager anytime anyway."

People's communication needs were met, records showed that for those that required the use of communication aids such as glasses and hearing aids that they had access to opticians and audiologists. We observed people wearing their glasses and using their hearing aids and the registered manager was observed asking a member of staff to ensure that a person was wearing their hearing aid. People were able to communicate freely with one another as well as to staff and there were lots of conversations and interactions throughout the duration of our inspection. Care plans showed evidence of good communication in the management of people's care between the provider and external professionals such as GPs and community nurses.

A handover meeting was observed between staff finishing the morning shift and those coming to work in the afternoon. Detailed information was provided to ensure that they were aware of people's needs and any events that had occurred that day, it also ensured that continuity was maintained and people received appropriate care and support. For example staff passed on information regarding people's health needs, changes in their condition and support needs.

People were supported to access appointments to ensure that their health and well-being was maintained. Referrals to health professionals had been made to ensure that people's health needs were met, for example in people's care plans we were able to see that people had seen various health professionals such as district nurses, occupational therapists, GPs and advocates. We asked people about their experiences of the health care they received. One person told us "If I need a doctor, they will organise it before I can." Another person told us, "I see the district nurses for my leg and they (staff) always let me know what's going on."

People's care plans showed that they had been asked to give their consent for the use of photographs in their care plans, physical examinations being undertaken if necessary, information held in their care plan being read by staff and that they were happy to be involved in the preparation, review and management of their care plan. We

were also able to observe staff gaining people's consent before offering support to them. One person told us "The staff know I have all my marbles and I make my own decisions. They don't interfere."

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. This related to two people who were unable to leave the service on their own due to risks to their safety and well-being. The registered manager fully understood the requirements of this legislation and had acted in accordance with it, therefore ensuring that people were not deprived of their liberty illegally. Within one of the DoLs applications there was a condition, staff were aware of this and there were arrangements in place to regularly monitor it.

Records of staff training showed that they had received training for the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, the update for this training had not taken place, however it was intended for staff to have refresher training imminently. We asked staff to describe their understanding of the legislation, they did not have a good understanding of the MCA, including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. However they had a good understanding of why the DoLs were in place for the two people living at the home, one member of staff told us "It's really about protecting people and keeping them safe," the staff were therefore able to help ensure that they worked in accordance with the DoLs and that people were kept safe.

People's preferences in relation to food was documented in their care plans. We were able to see that in one person's care plan they had specified that they enjoyed eggs for breakfast. This person had been losing weight so staff were cooking eggs on toast for the person for breakfast, therefore ensuring that her preferences were met. Menus were devised according to people's likes and dislikes, however the registered manager acknowledged that it was sometimes difficult to please everyone, therefore alternative choices were offered to people if they didn't want to eat the main meal. Feedback had been given by people commenting that they no longer liked liver and bacon, this had been taken on board and was subsequently taken off of the menu. We were able to see that a person who had a very specific and limited diet due to their health needs and was therefore at risk of malnutrition was able to choose alternative food and that their choices had been respected and catered for.

We asked people about their experiences of food and drink at the home. One person told us "The food is about average." Another person told us "I like the food. It's home cooked." We observed food being served at lunchtime. People were able to choose where to eat their meals, the majority of people chose to eat in the main dining room, whereas others chose to eat in their rooms. The dining room was pleasant, clean and tidy and created a relaxing, social environment for people to eat their meals. The tables were presented nicely with a vase of flowers as well as condiments to season and flavour their food, helping to aid people's orientation and meal time experience. People were observed eating a home-cooked meal, they appeared to enjoy the food and were asked if they would like seconds. People were offered a choice of drinks and were offered support by staff if they needed it. When we asked people earlier in the day what they were having for lunch they were unable to tell us, however this was displayed on a board in the dining room and staff explained that people are asked in the mornings what they would like to eat. This helped people with short term memory loss to receive the choice of food they wanted as it was unlikely they would remember food choices made the day before.

Good

Is the service caring?

Our findings

People were cared for by staff that had a compassionate and caring manner. People told us that they felt that the staff were caring, one person told us "The staff are very kind. They work with you." A relative told us, "The staff are brilliant, the best we've come across I'd say. They always tell us if something is happening or if there's been a change."

There was a caring atmosphere in the home, interactions between staff, the registered manager and the people that lived at the home were respectful and positive. It was apparent that the staff knew people well, they knew their likes and dislikes and people were supported in a way that respected their wishes. A health professional told us "The people are extremely well cared for and I have never had any concerns." Another health professional told us "I have never found fault with this home, so much so that I would recommend it to family and friends."

We were able to see compliment cards from relatives to the registered manager and staff, these showed that they were very happy with the care people had received, one of them read "Thank you for the loving care which you and your staff show to my relative." Another said "Wonderful care and kindness that you have given to my relative."

Staff showed compassion and kindness when supporting people and spent time talking and listening to them, there was lots of laughter and engagement and it was evident that people enjoyed interacting with the staff. For example when staff offered assistance to a person to go to the conservatory for morning tea they shared a joke and some banter with one another and the person really appeared to enjoy the interaction. For another person who chose to spend time in their room staff ensured that they checked on the person to see if they were okay and if they needed anything, they also spent some time enjoying conversations about things that were important to the person to ensure that they weren't isolated when in their room.

During our observations we were able to see how staff responded to a person who was distressed about their health. Staff took time to speak to the person, listening to their concerns, they offered reassurance and asked the person if they would like to speak to the registered manager about their feelings, this was then arranged and the registered manager also spent time with the person until they felt reassured and less anxious. Later in the day the registered manager noticed that the person was sitting alone in a quieter part of the house, she ensured that she asked the person if she was okay and if she needed anything. This demonstrated that the registered manager was mindful of this person's feelings from earlier in the day and that despite being occupied with other tasks took time to ensure that the person wasn't distressed.

Caring relationships had also been developed between people that lived at the home. People enjoyed conversations with one another over tea and lunch and appeared to care for one another's well-being.

People's differences were respected and people were treated equally. There was a resident's charter of rights that states that people have the right to choose and wear their own clothes, this had been implemented as people's preferences regarding their clothing and appearance were documented in their care plans, for example in one person's care plan it stated that they liked to wear make-up, we were able to observe that this person had styled their hair and was wearing make-up. Another person had chosen to wear trousers as they knew that they wanted to participate in an activity that day and wearing these would ensure that they were able to participate more effectively. The resident's charter of rights also states that people should have their religious and cultural needs accepted and respected. There was a monthly church service, other religious needs had been catered for in the past, for example for one person who was catholic the staff had arranged for a priest to visit the person regularly. People were also able to retain their own religious leaders who visited them in the home if they preferred.

Observations of interactions showed that staff always consulted people before offering assistance, they gained the person's consent and explained their actions. For example we observed people being asked if they required assistance to move from the lounge to the dining room or if they needed to use the toilet facilities. Staff treated people in a respectful and dignified way, when asking people if they required support they did this discreetly, kneeling beside the person or talking quietly to them. When one person was talking to staff about the concerns about their health staff were mindful that other people might of overheard so spoke in a quiet voice and went into another room to discuss the person's concerns with them.

Good

Is the service caring?

The aims and objectives of the home state that privacy will be maintained by protecting the rights of people if they wish to be left alone and free from intrusion, it also states that dignity will be promoted as if people require assistance with personal care this will be treated by staff with respect.

We asked people how their dignity and privacy was maintained. One person told us, "The staff always knock before they come in my room." Our observations on the day confirmed this. Another person said, "They don't talk over me. They always listen to me." Peoples privacy and confidentiality were maintained in relation to the information that was held about them in records, these were stored in locked cupboards that were only accessible to staff, this complied with the homes policies and procedures in relation to confidentiality.

People were involved in decisions about their care and the support that they received. When people first moved into the home they were involved in devising their own care plans and deciding how they wanted to be supported. People told us that they had been involved in making decisions about their care and treatment. One person told us, "I don't think they (staff) would do anything without my permission." A relative told us, "The manager is good like that. They don't make decisions without asking us first."

When people are unable to understand decisions or make their views and wishes known, they may use an advocate. An advocate is a person who might help a person to access information, accompany them to meetings and appointments in a supportive role, write letters or speak on their behalf. Records showed that one person had been assessed by an Independent Mental Capacity Advocate, this person had been assessed as needing the support of an advocate and we were able to see that within the person's care plan there were plans for them to be visited by an advocate every 6-8 weeks. This demonstrated that the registered manager had ensured that all people had equal access to being involved in the decision making process despite their levels of ability or needs.

Within the home's aims and objectives it stated that the independence of people will be actively encouraged. People were able to be independent. Staff were aware of the importance of promoting people's independence as they had made referrals to occupational therapists to ensure that people had the correct mobility equipment to maintain their mobility and independence. People were able to do things for themselves, staff offered support but were observed asking people if they needed assistance before supporting them with anything. The registered manager explained that if a person could do something for themselves then staff encouraged them. One person confirmed this as they told us "The staff are very caring. I do a lot of things for myself but they are there if I need them." During our inspection we were able to observe one person laying the tables with cutlery, condiments and serviettes, the registered manager explained that this is something that the person enjoys doing and takes pride over and is something that is encouraged to maintain the person's independence.

Dependent on a person's health and mobility needs they were able to stay at the home until the end of their life. The homes guide states that care and comfort will be provided to people that are dying. Care and support had been provided to people in the past, although staff did not receive specific end of life training the registered manager told us that support is gained from external professionals such as district nurses and that experienced staff had been allocated to offer support to people at the end of their lives. Evidence showed that the appropriate equipment had been sourced to ensure that people could remain at the home and be cared for in an appropriate way, for example a hospital bed and air mattress had been purchased so that pressure sores were prevented as people did not want to go into hospital. People were able to choose how they wanted to be supported and cared for at the end of their life, the registered manager explained that conversations with people and their families had taken place to ensure that all staff knew what the people want and how they want to be supported.

Good

Is the service responsive?

Our findings

People felt that their needs were taken into consideration when staff were providing care and support to them. One person told us, "The staff have all been here years so they know us really well." A health professional told us "Staff are responsive to people's needs and this is born out of the fact that people feel safe, comfortable and well looked after."

A person-centred approach to care is about seeing the person as an individual rather than focusing on their illness or the abilities they may have lost. It is about considering the whole person, taking into consideration their uniqueness, abilities, interests and needs and preferences. We asked staff what they understood by the term 'person centred care'. One staff member told us, "Well, it's giving individual care. We're all individuals." Another staff member told us, "We know them really well, so we can make sure they get the right care."

A person-centred approach had been used, records contained information about life histories, social assessments and profiles. The purpose of the profile is to learn about the life of the person. The process establishes a good relationship between staff and people and can be an important source of information for the care plan and the support and care offered by staff. Care plans had been compiled in conjunction with people and their families and contained information staff could use to help build relationships, for example, people's previous occupations and hobbies. For one person their care plan explained that they liked to wear make-up, do their hair and wear a certain item of clothing. We were able to see this implemented as the person was observed wearing the clothing and had done their hair and make-up, this appeared to give the person pleasure as they spoke with us about it. The person had also been able to specify what time they liked to go to bed and what daily newspaper they liked to read. The registered manager explained that she had contacted the person's social worker to arrange for a paper to be paid for and delivered to the home daily as it gave the person such pleasure, we were able to see that this had been arranged and the person was observed reading the newspaper of her choice.

The Churchley Residential Home guide that is given to people when they first move into the home, stated that a member of staff would review their care plan monthly. Care plans had been reviewed monthly and people were happy that their care needs were being met and that they were supported appropriately. The registered manager explained that they are responsive to people's needs and changes will be made to the support that they receive if they make their wishes known or if they are noticed by staff. Reflecting on a situation the registered manager told us about a person who had said that they missed having fresh coffee, therefore this person now has fresh filter coffee instead of instant.

One of the aims of the home is to ensure people lead fulfilled lives, they state that they encourage people to lead active lives, both physically and mentally, through the provision of as many occupational activities and outings as possible. There was a timetable offering a range of activities, these included floristry, photography, coffee mornings, music and sing-a-longs, and theatrical make-up classes, external professional music groups, bingo, word games, reminiscence and keep fit exercise classes.

We asked people about the availability of social, educational and occupational opportunities at the home. One person said, "There's not a lot of activities going on." Another person told us, "I'm tired of sitting here. There's bingo and not much else." Records showed that people's interests and hobbies had been taken into consideration and their participation in activities had been recorded. Photographs showed people participating in activities and there were floristry arrangements decorating the home that people had made. The registered manager said that the activities offered to people were based on their preferences, if an activity went well then it was offered again, if it did not then an alternative was found. A relative's survey had been conducted, one comment said "The organised entertainment seems to go down well and it's nice to encourage the use of the garden, which is lovely."

People were seen interacting with one another and choosing how they spent their time. Some people chose to spend time in the communal lounges, enjoying tea and conversation with one another whereas other people chose to spend time in their own room, staff were mindful of this and spent time with people in their rooms to reduce social isolation. During the afternoon we were able to observe an exercise class that was offered by an external company, this was well attended and people were engaged and appeared to really enjoy the activity. The activity was suited to the needs of the people, informed them of the

Good

Is the service responsive?

benefits of the exercise to them and what muscles they were using. People appeared to find the session enjoyable and informative, often asking questions and making comments about the exercises.

People's choices in regards to how they spent their time, what they had to eat, what they chose to wear and how and when they were supported were respected by staff. We were able to see evidence of this within people's individual care plans, through observations of interactions between staff and people and from what people told us. People were treated as individuals, their right to make choices and decisions was respected and the staff were responsive to people's needs. For example, we saw that a curtain pole and curtain had been put up across a person's bedroom door, when we asked the registered manger about this she explained that the person said that she could see light around her bedroom door at night and it was disturbing her sleep. The curtain had been installed and the person could sleep much better and had less disturbed nights.

There were no formal concerns or complaints, however we were able to see that there was a complaints procedure in place for people and their relatives to use and people were informed of their right to make a complaint when they first moved into the home. The registered manager explained that there had been no complaints for two years and people confirmed that they didn't feel the need to complain. Within the results of the resident's survey one person had said "I'm quite happy, no complaints." Another person had said "I've got no complaints, I'm as happy here as I was at home."

Requires improvement

Is the service well-led?

Our findings

People were positive about the management of the home. One person told us "The manager is always around to ask if I want to know something." Staff were equally as positive about the manager, when we asked them if they felt that the service was well-led one member of staff told us "Yes, I think it is. The manager is really good and you know where you are." However, despite the positive comments from staff and people we found areas of practice that required improvement.

Effective quality monitoring systems should be in place to monitor the systems and processes within a care home to ensure that the services they deliver are effective and to determine if improvements are required. The registered manager undertook a quality monitoring audit for the accidents that occurred, analysing the amount of falls that people had over a year, if this reached a certain amount she would ensure that necessary action was taken. By undertaking these audits the registered manager had been able to implement changes to ensure that people's safety was maintained, for example introducing a call bell pendant for a person to wear.

Although no formal residents or relative meetings took place within the home, people and relatives were asked their opinions through an annual survey, this asked various questions about the home and the support provided. The results of these surveys were displayed for people to see and were positive. One person had commented "I am happy with the level of care, I feel I receive enough assistance when I need it." The results of the relative's survey were equally positive and one relative commented "It gives me great peace of mind knowing that my relative is being looked after at Churchley. I couldn't ask for more." The registered manager told us that if people indicate that they are unhappy about anything in the home then she uses the information to make changes, she told us "There is no point having a feedback form and not acting on it."

However the registered manager did not have robust quality assurance systems and processes within the home. For example the dispensing and administering of medication was not audited. When we looked at the medication administration record (MAR) charts we found some errors that had not been noticed by anyone in the home, this could have had a potentially negative effect on people, a regular quality monitoring system would have highlighted this and therefore potential risks highlighted. The lack of effective quality monitoring for the range of systems and processes used within the home, such as the auditing of care plans which would have highlighted the lack of fluid and food monitoring charts for people at risk of malnutrition, could have resulted in people receiving inconsistent care and a poor quality service.

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

Part of a registered managers responsibilities under their registration with the Care Quality Commission is to have regard, read and consider guidance that is provided in relation to the regulated activities that they provide, as it will assist them to understand what they need to do to meet the regulations. One of these regulations relates to the registered manager's responsibility to notify us of certain events or information. The registered manager had followed correct practice by ensuring that two people who lived at the home had their capacity assessed in accordance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However providers are required to inform CQC of these assessments and applications to enable us to have oversight to help ensure that appropriate actions are being taken and to be aware of when people are being deprived of their liberty, this had not happened. When we raised this with the registered manager she was unaware that she needed to notify us of this.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There were organisational policies that provided guidance to staff, these were not current. Policies need to be updated to reflect changes in guidance and to ensure that organisations are complying with legislation. This had not taken place and as a result staff had out of date guidance that didn't reflect current legislation. For example policies were not updated and staff were not made aware of changes in relation to safeguarding since the Care Act 2014. Having up to date guidance for staff is an area that needs to be improved.

The aims of the home were to provide people with the opportunity to enhance their quality of life, by providing a safe, manageable, comfortable and homely environment. The philosophy statement of the home advises people that

Requires improvement

Is the service well-led?

they can expect to live in an environment, that regardless of their level of need, they will have the same rights and responsibilities as anyone else, and be able to live an ordinary and independent lifestyle in a homely environment. Staff were aware of the aims and culture of the home. One staff member told us "To make this place a home from home." Another staff member told us, "Making people safe and making sure they are well cared for." The aims and philosophy were embedded in the culture of the home and the practice of the staff, we observed that there was a homely atmosphere, people appeared to be comfortable and were able to spend their time as they wished. One relative told us "The staff are great. It's like a home from home."

The home was managed by a registered manager and a deputy manager. The registered manager was a role model for staff and had a visible presence within the home, she was observed spending time with people, listening to their concerns and assisting them when needed. Communication between the staff team and the registered manager was good they worked as a team together and were able to immediately share relevant information with one another to assist in the running of the home and the support that people received. There was a culture of openness and transparency and staff told us that the manager operated an 'open door' policy and that they felt able to share any concerns they may have in confidence. A health professional told us "The managers are always very responsive and excellent at their job."

Links with the local community were maintained, the registered manager explained to us that external organisations are invited into the home. These included pets as therapy sessions, where a local farm brings various animals into the home each month for the people to see and pet. There are also musical entertainers and volunteers that work at the home. The registered manager explained the importance of these links with the community, explaining that the people that live at the service really enjoy the interaction and entertainment that they offer.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment** **The registered person had not taken the appropriate action to ensure that care and treatment was provided in a safe way for service users.** **The registered person had not taken the appropriate action to ensure the proper and safe management of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.** **The registered person had not assessed, monitored and improved the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of experience of service users in receiving those services)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **Regulation 18 (4A) (a) (b) (4B) (a) (b) of the Care Quality Commission (Registration) Regulations 2009. Notification of other incidents.**

This section is primarily information for the provider

Action we have told the provider to take

The registered persons had not notified the commission of any application or authorisations made in relation to depriving a service user of their liberty.