Platinum Care Homes (Stanwell) Limited

Church View Care Home

Inspection report

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Date of inspection visit:
02 December 2021

Date of publication:
08 February 2022

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Church View Care Home is a care home providing accommodation, personal care and nursing care to 69 people aged 65 and over at the time of the inspection. The service can support up to 78 people, many of whom may be living with dementia or a learning disability. People live in one adapted building, divided into six separate living areas, each with their own lounge and dining room.

People's experience of using this service and what we found
Although we received some positive feedback about staff and were told some of them were kind, we found a lack of person-centred, individual care being provided. Staff did not always know people or take time to read their care plans to familiarise themselves with risks associated with people. This resulted in people being in danger of potential harm. Some people told us they felt unsafe with staff and we found staff did not have a good grasp of how to identify or report any safeguarding or other concerns they may have. Due to this lack of understanding we could not be confident that all potential safeguarding incidents were being identified and reported.

People said they often had to wait for staff, sometimes for a significant amount of time and we observed non-care staff sitting with people as there were insufficient care staff on the floor. Staff did not always take the time to speak in English in front of people and we found some staff were not fluent in English.

The registered provider was not checking staff were always following suitable infection control practices. This related to the wearing of personal protective equipment and handwashing practices and new staff, who were new to care, were not provided with a robust induction.

People did not receive care in line with their individual wishes and we heard that some people were, "Bored" as there was a lack of activities taking place. This was particularly relevant to those who spent a lot of time in their rooms. People's care plans lacked information on people's backgrounds, hobbies and preferences which meant staff could not learn about a person to use information to help build relationships.

Although accidents and incidents were recorded and analysed and action was taken in response, the registered manager had not learnt from our previous inspections where we highlighted shortfalls. They had failed to ensure people were kept safe at the service and they had failed to consistently provide a good level of care to people.

People were not given the opportunity to contribute towards the running of the service as feedback was not sought from them.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make

assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right support:
Model of care and setting did not maximise people's choice, control and independence. We found people were not supported with individualised activities to meet their specific needs. People were not supported to access the community.

Right care:
Care was not person-centred and did not promote people's dignity, privacy and human rights. We found a mix of people living at the service and as such people's individual characteristics and needs were not always recognised by staff. Staff did not always take time to read people's care plans and were unable to tell us about people.

Right culture:
Ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using services led confident, inclusive and empowered lives. We found people received care from staff who may not know them well and staff who did not always speak English in front of them. People were admitted to the service without the registered provider considering if it was an appropriate setting for them.

Despite identifying concerns at our last inspection and the registered provider telling us they would address these by 31 March 2021, we found this not to be the case. We found continued breaches of regulation and areas of concerns which had not been identified by the registered manager through their governance processes.

We did find however, that people received their medicines correctly. Some people told us staff at Church View could not do any more for them and they were happy living at the service. In turn, staff we spoke with on the day said they enjoyed their jobs.

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

Rating at last inspection and update
The last rating for this service was Requires Improvement (report published 18 January 2021) where breaches of regulation were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection not enough improvement had been made and the provider was still in breach of regulations. There were also further shortfalls identified and as such the service has deteriorated to Inadequate.

Why we inspected
The inspection was prompted in part due to concerns received about people experiencing a high level of falls, lack of induction for staff, a bullying culture within the staff team, poor record keeping and lack of staff and activities. A decision was made for us to carry out a focused inspection and examine those risks. This report only covers our findings in relation to the key questions Safe, Responsive and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has deteriorated to Inadequate. This is based on the findings at this inspection. You can see what action we have asked the provider to take at the end of this full report.

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

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We will meet with the provider and work alongside them and local authority to monitor progress.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Church View Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
The inspection was carried out by three inspectors.

Service and service type
Church View Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We reviewed the information of concern we had received to ensure we focused on the appropriate areas during our inspection.

During the inspection
At our inspection we spoke with 15 people who lived at Church View Care Home and three relatives to obtain their views on the quality of care provided. We also spoke with the registered manager, deputy manager and 13 staff. We reviewed information held in 14 people's care plans, four staff recruitment files, medication records and other paperwork related to the running of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at staff rotas, people's care plans, quality assurance information and training data.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to a failure to manage risks associated with people in a safe way. We found similar concerns at this inspection and the provider was still in breach of regulation.

- People were not always kept free from harm due to staff's lack of understanding and knowledge of people's care plans or potential risks. Despite the registered provider telling us in their action plan that by 31 March 2021 people's care plans would be reviewed and processes put in place to ensure staff were provided with information around people's risk, we found this was not the case.
- People who slept on a pressure mattress (to help protect them from developing sores) had their mattresses set incorrectly. One person who weighed 48kg had their mattress set at '160'. We asked the registered manager what this setting represented but they were unable to tell us. They consulted with the deputy manager, who in turn consulted with the housekeeper and we were told the mattress was, "Self-regulating." However, we spoke with one of the nurses on duty who told us mattresses should be set in line with the person's body weight. Following our conversation, this person's mattress setting had been changed to 50kg.
- A second person's mattress was set at 70-90kg and yet they weighed 50.5kg. We asked a staff member about this person. Initially they said, "[Person's name] who's [person's name]?" They went on to tell us this person did not have any sores or wounds. However, we had already seen in this person's care plan that they had a wound on their knee. This showed us staff were unaware of people's risks and risks were increased as equipment was not used correctly.
- A third person was at high risk of falls. They told us, "I can't have a shower." When we asked why they told us there was no shower seat available for them and instead they had to sit on the toilet in their en-suite. This put the person at risk whilst receiving personal care.
- One person was seen in their wheelchair all day sitting on a pressure cushion. The registered manager told us they were at high risk of pressure sores. However, they were sitting on another person's pressure cushion which demonstrated staff had not ensured pressure equipment was specific for the person and their individual needs.
- Much later in the inspection we found one person in their bed with their call bell out of reach. They were distressed, but had no way of attracting staff's attention. We found when we picked up the call bell, the lead had been pulled slightly out from the socket meaning even if they had been able to reach the call bell it would not have worked.

Preventing and controlling infection

● We were somewhat assured that the provider was using PPE effectively and safely. During the morning, the registered manager brought some documentation to us whilst we were in one living area. They came into the living area without a mask on. We also observed a relative assisting their family member to eat whilst in the lounge area of one living area and noted their mask was down below their chin. We had no concerns about the rest of the staff team and their use of PPE.

● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. Although we found the service clean and tidy and saw housekeeping staff carry out cleaning tasks throughout the day, it was evident staff were not following good infection control practices. We found four sluice rooms (areas for cleaning soiled items or disposing of soiled continence aids) where the sinks were bone dry. This indicated to us that staff were using these rooms but not washing their hands before leaving, despite signs on the doors reminding them to do so. We also saw some people's beds bumpers were dirty and stained. One bed bumper had drink drips down it.

The failure to tackle shortfalls to address risks associated with people or follow good infection control practices was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people's risks were identified and addressed. One person required bedrails as they were at risk of falling out bed. We saw a bedrail risk assessment in place. We also saw a staff member spend time supporting someone, who needed to be accompanied by staff, to walk around the living area.

● A second person was at high risk of malnutrition and staff were required to weigh them weekly to monitor their weight. We saw from the records this was happening and noted the person had gained 3 kilograms in the last five months.

● When staff were concerned about someone in relation to their weight, referrals were made appropriately to health professionals. For example, the dietician or GP. The deputy manager reviewed each person's weight monthly to identify any concerns. A relative told us, "He has put on weight, which is great, as he is eating properly now."

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

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

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

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

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

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

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Using medicines safely

At our last inspection, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to poor medicines management practices. We found no similar concerns at this inspection therefore the provider was no longer in breach of regulation.

● People told us they received the medicines they required. One person said, "I get my medicines" and another told us, "They are very good with my medicines."

● People had medicine administration records which included important information about them, such as any allergies, the name of their GP, their medicines type, dosage and frequency and whether they were on any 'as and when' medicines.

● We saw the medicines trolley was locked whilst staff gave people their medicines in their rooms and found the clinical room was clean and tidy.

Systems and processes to safeguard people from the risk of abuse

● People gave mixed feedback on whether they felt safe. One person told us, "Some [staff] are unkind. Sometimes it's the way they speak to you. I feel safe with some, but not with all." A second person told us, "Yes, I think I feel safe. Some [staff] are rough, occasionally they grab hold of your arms, but I am never fearful." However, other people told us, "I've never thought about it (being unsafe)" and, "If you see someone you don't know, you can just press your bell." A relative told us, "At the end of the day he is safe here, which at home he was not."

● However, upon speaking with staff, we did not feel assured they understood how to recognise potential abuse, or how to report it. A staff member said, "I have no idea who the lead [safeguarding] agency is." This same staff member when asked if they knew how to whistle blow said they would have, "No idea and I don't know if I would be willing to do it." They added, "Staff are worried about speaking up."

● We asked a further staff member if they could tell us what safeguarding meant and they told us, "I raise concern….I'm sorry, I don't know."

● Safeguarding concerns had been raised by the service to the local authority. The registered manager kept a log and carried out any investigations required by the safeguarding agency. However, although these safeguarding concerns were raised by the service to the local authority, we did not feel staff understood how to recognise potential abuse, or how to report it.

The lack of understanding by staff on safeguarding processes and concerning feedback from people demonstrated a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection we issued a recommendation to the registered provider in relation to staffing. We found similar concerns at this inspection.

● People gave mixed feedback about staffing. One person told us, "Downstairs staff are better than up here. Sometimes I can wait an hour." A second person told us, "I suppose there are enough [staff] but I get fed up waiting. They don't come quickly." A third said, "There are not enough. They are short, they could do with more. They are always rushing around too much." However, other people told us, "If I need them, they're there. I have an orange bell to call them," "Staff are always around," "I just ring my bell and they come within two minutes. Even if it's to say they'll come back, and they do."

● Relatives also gave us mixed feedback. One told us, "They are pretty good. However, there are times when no one is around and it's quicker to walk along the corridor and find someone. There are usually three, but today there seems to be five. It may be because you are here."

● Some people were affected by staff deployment. One person told us, "My catheter parted company this morning and I got all soggy. I am waiting to be changed. I thought they (staff) were going to come back, but I'm still waiting. My trousers are dry now. I feel like a lost bit of luggage - just forgotten about." We alerted staff to this person and they went to provide care to them.

● We saw times during the day where no staff were in lounge areas and people were on their own. On one occasion in a living area, we observed a staff member sitting with people. They were watching the television. We asked a nurse if this staff member was the activities lead, but were told, "No, it's the housekeeper. She is sitting with people whilst staff answer the call bells." The staff member sat in the lounge for over 20 minutes which demonstrated to us that there were insufficient care staff on the floor.

● Staff were not given induction and supervision when new to the role. A staff member told us, "New staff are not shadowing, even when the caring job is new to them." A second staff member said, "During my induction, I was introduced to residents and care plans." However, when we asked them if they had read people's care plans, they told us, "I read the care plans – often when I am feeding residents."
● A new staff member had started on the morning of inspection. We observed them on their own in the lounge area with people. Although they told us they were receiving induction, there was no permanent member of staff supporting them and staff were unable to tell us who was mentoring them. When we asked if they had time to read the care plans, they told us, "I don't know what you mean."
● Despite many people living with dementia, the registered manager did not check that agency staff working during our inspection had received dementia training.
● We were told team leaders undertook medication dispensing and were provided with evidence of their annual medicines training records. However, the registered manager was unable to provide evidence to us that they carried out annual competency checks on these staff to ensure they were putting the training into practice and following safe medicines processes. Following our inspection, the registered manager provided us with evidence of competency checks carried out for staff.

The failure to suitably deploy enough staff who were competent and properly trained for their role was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were employed following a recruitment process. This included an application form, proof of ID, references and undergoing a Disclosure and Barring Service (DBS) check. A DBS helps ensure that prospective staff are suitable to work in this type of environment.

Learning lessons when things go wrong
● The deputy manager carried out monthly audits of accidents and incidents to look at trends and themes. They shared the most recent analysis with us. These recorded the overall monthly incidents, together with a breakdown of times and type.
● The service had been subject to a number of falls in recent months and we asked the deputy manager if they had acted in response to this. We were told they had identified that most falls related to people having just moved into the service. They said, "COVID has had an impact. People have been home alone and fall, ending up in hospital. We cannot do assessments in hospital, so rely on the information that we are given. We can't assess people properly until they are here, and the hospital are discharging people too quickly." They added, "As a result, we are working more closely with families to obtain information and we have introduced more 1:1 support for a short period when people first come to us."
● We reviewed the information we had received from the service relating to falls and were able to confirm that out of the nine most recent falls, six of them related to people who had just moved to Church View.
● However, despite the registered manager taking action in response to these falls, we felt that following the concerns raised at our last inspection, the registered provider and registered manager had not considered what lessons could be learnt to ensure that people received safe and consistent care.

We recommend the registered provider takes responsibility to learn from previous concerns identified at the service to satisfy themselves that there is no reoccurrence.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns
At our last inspection, we identified a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to relatives telling us they felt their complaints were not investigated properly. We found some progress at this inspection and the provider were no longer in breach, however records relating to complaints required further improvement.

● Following our last inspection, the registered provider told us they would send out a copy of the complaint's procedure to all relatives as a reminder of the process. This meant, people and their relatives, would know how to make a complaint or raise a concern when needed.
● However, despite the registered provider telling us in their action plan that they would, 'maintain a record of all complaints, outcomes and actions in response to complaints', we found this not to be the case. The registered manager showed us complaints and their response to them, but there was no record of whether the complaint had been resolved to the complainant's satisfaction and as such the matter closed. We spoke with the registered manager about this who said they would start an electronic log to improve the records. We will check at our next inspection whether this has happened.

We recommend the registered provider keeps robust records in relation to complaints.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● People did not always receive person-centred care. We visited one living area at 18:00pm, we found everyone in bed and at 18:15pm, we heard a staff member say, "Goodnight" to one person. We found someone very distressed in their bed telling us they did not want to be in bed and wanted to be in the lounge. Their care plan stated this person liked to go to sleep at 20:30. After speaking with staff, they got the person back out of their bed and took them to the lounge.
● A second person required their bed to be at the lowest level whilst they were in it. However, we saw this was not the case and this person's bed had bed rails on it. These were not mentioned in their care plan which meant a risk assessment had not been carried out to ensure these were the most suitable equipment for this person or that they were at risk of entrapment.
● We saw another person in a wheelchair with a bean bag as a foot stool. Staff told us this was to prevent them rubbing their ankles together and making them sore. However, the registered manager told us it was because their feet did not touch the floor when sitting in the chair. In addition to staff not considering providing a wheelchair where this person's feet could touch the floor, there was clear confusion between

staff and the registered manager around why this person had the bean bag.

● We identified a mixture of staff's understanding and knowledge of people. We asked one staff member why someone had come to live at the service and what their primary diagnosis was. They told us, "Mmmm, dementia? I don't know." Other staff said they did not have time to read people's care plans. One staff member said, "No, I haven't got time to read but if I'm not sure I will ask the nurse or my colleagues." However, others told us the electronic care planning system was easy to use. A staff member said, "I can see the care plans on there, allergies and everything. It is clear what you need to do for them [people]." We also heard from other staff information about people which was in line with their care plans.

● People were not receiving care in line with their individual personal care wishes. One person had requested a weekly shower or bed bath; however, we saw from their daily records that during the month of November 2021 they were not supported to have one shower and only had eight bed baths. A second person liked a, "Strip wash in bed" however, there were eight occasions during November 2021 when they did not receive this.

● Care plans were contradictory. One person said they had a good understanding of 'normal conversation', but later said they were unable to indicate their needs. Later in their care plan it was recorded they had a preference to be left alone, but further on stated they were sociable.

● People had no information about their background in order to enable staff to get to know them. There was nothing about their previous jobs, family details, hobbies or interests. The registered manager told us there was a, 'This is Me' section in care plans. These were held either electronically or in paper format. However, when we looked at some samples they showed us, these were in fact, hospital passports, containing relevant information should a person be admitted to hospital.

● There was a lack of information in people's care plans around their end of life wishes. We reviewed two people's care plans who were nearing their end of life and the only information recorded for one person was that they had a, 'do not resuscitate' instruction in place. The second person had no information recorded at all.

● Other people did not have end of life care plans at all. This meant if someone's health deteriorated quickly staff would be unaware of people's wishes.

● People did not live in a stimulating environment and we received mixed feedback about activities, despite staff telling us they organised a range of activities for people. There was one activity staff member on duty during our inspection for the six living areas. One person told us, "I do get bored. We don't really do activities." They told us they were, "Excited" to go to the knitting club later that day. However, we saw this did not take place. A second person said, "There is always something to do (in my room)." A further person told us, "Staff occasionally come in and talk. There's not a huge amount going on that I can join in with." A relative said, "She [person] would benefit from more stimulation and activities."

● A large majority of people remained in their rooms and they said there was a lack of 1:1 activities arranged for them. One person told us, "I get very bored. I feel isolated and I don't get company." A second said, "They [staff] rarely come and speak to me. They only talk when they're doing tasks."

● Staff were not meeting the needs of people with a learning disability. One person's care plan asked staff to provide activities in line with their diagnosed needs and to encourage them to participate. National guidance requires services that support people with a learning disability or autistic people to ensure the size, setting and design of the service meets people's expectations and is aligned with current best practice. It also requires services to support people with a learning disability to access and be a part of their local community in line with their preferences and social needs. Although the registered manager told us following our inspection, this person also had nursing needs, there was no indication that the guidance had been discussed with them, or evidence that appropriate activities or leisure interests had been offered to them.

The lack of person-centred care, end of life care planning and providing activities to meet people's needs

was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We did observe some nice interaction between staff and people and there was a friendly atmosphere in some areas of the service. Staff were proactively engaging with people in one living area during the morning, playing music and encouraging people to sing along. When someone new came into the lounge area, they were greeted warmly by staff.
● Staff checked on people's welfare, asking if they were warm enough and bringing blankets for those who requested them. When one person, who had poor mobility, got up from their chair, staff were quickly by their side to support them to walk.
● People were able to make their own decisions at mealtimes. We heard people request to have lunch in their rooms or to eat in the lounge area, rather than go to the dining room. One person told us, "I have just had a lovely lunch. I thoroughly enjoyed it. We are treated very well here."
● Another person who was in bed told us, "I am just lying here. I would like to see what the trees look like and how much the grass has grown. It would make all the difference in the world." We saw during the afternoon staff had supported this person to get up and go for a walk.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● We received feedback that staff understood people's individual communication needs. One person said, "They [staff] know I am deaf and waiting for a hearing aid, so they come close to speak to me." A relative told us, "Staff do know [person]. They know from her gestures what she is trying to say."
● There was information around the service displayed in an appropriate way and signage to enable people to identify specific areas around the building.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to mixed feedback from people and relatives about the management of the service. It was also due to a lack of robust oversight of the service to help ensure care records were detailed and accurate. We found similar concerns at this inspection in addition to identifying new breaches of regulation in all of the key questions we inspected on. Therefore, the provider is still in breach of Regulation 17.

● We identified a failure of systems and processes which meant people did not receive safe, person-centred, individualised care.
● We had carried out this focused inspection following receipt of concerns around a high number of falls, lack of induction for staff, a lack of staff and activities and a culture of bullying and intimidation within the service from management to staff.
● Despite the reports of bullying, during our inspection most staff told us they were happy with management and we did not receive feedback from them that they felt bullied or harassed. Some staff did tell us though, "[Registered manager] isn't on the floor much. She says she supports us, but I don't see her doing it" and, "Big internal problems. Staff are not ready to open up. Staff are scared and stressed." However, we identified other significant shortfalls at the service which meant people did not experience good outcomes whilst living at Church View.
● There was a lack of positive culture within the service. Staff did not have a good command of English. We heard from people that staff often spoke in their own language in front of them which made them feel uncomfortable. One person said, "Sometimes they [staff] don't speak to you. They speak in their own language." A second person told us, "They speak in their own language. I don't think they should." A third person said, "I feel terrible when they speak their own language. I feel like they might be speaking about me."
● We found there were instances when staff struggled to comprehend our questions and one staff member told us, "Please be careful, my English is bad." A staff member came into one person's room whilst we were there to discuss their menu choices for the day. However, the staff member did not understand the menu and what was on offer due to their lack of English, which left the person confused.
● People and their relatives gave a mixed response when we asked them if they knew who the manager was. One person told us, "My son knows her, and I know her. But, it's rare to see her." A second said, "I've been

told to speak to [registered manager's name] but I don't know who that is." Others however, told us, "[Registered manager's name] is lovely" and, "The manager does come around every now and then." A relative said, "[Registered manager's name] is very good. She is very helpful."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● The registered provider had failed to ensure good management oversight of the service was in place to act upon concerns identified at our previous inspection. This was despite the registered provider telling us in their action plan they would make improvements. They told us, 'the provider will monitor progress against plans to improve the quality and safety of services and will take appropriate action to achieve the expected outcomes. By regular auditing the provider will identify the risks to service users and appropriate action will be taken to minimise the risks'. We found a number of continued breaches at this inspection which we have detailed throughout this report.

● There was a lack of systems and processes in place to enable staff to identify and assess risks to the safety and welfare of service users. The registered provider had failed to ensure service users were provided with suitable and appropriate equipment and that equipment was used in the correct way. This meant an increased risk to people being harmed. Staff did not follow good infection control practices which put people at risk, particularly in relation to contracting COVID-19.

● The registered provider had failed to ensure there were sufficient staff deployed in the service which meant people had to wait to receive care. Staff were not given time to read people's care plans which meant staff were not aware of people's individual needs and as such people did not always receive care in line with their wishes.

● There was a lack of systems in place to ensure people's social and leisure needs were being met and that care was planned and delivered taking into account nationally recognised evidence-based guidance. The registered provider was not meeting the needs of people with a learning disability and people said they were, "Bored" as there was a lack of stimulation at the service.

● People's care records were not contemporaneous as staff had not taken the time to record people's history, their interests, hobbies or previous jobs. Where people were at the end of their life, staff had failed to ensure they were aware of people wishes on how they would like to be cared for during this time.

Working in partnership with others; continuous learning and improving care.

● Where accidents and potential safeguarding incidents occur, we had received notifications appropriately. However, the registered provider had not ensured all staff understood how to identify or report safeguarding concerns. Therefore, we could not be satisfied that all incidents of potential abuse had been brought to the registered manager's attention. Some people told us they felt unsafe living at Church View.

● The registered manager worked with the local authority safeguarding team to investigate any safeguarding concerns in line with their requirements. The registered manager kept a log of safeguarding incidents only marking them as completed when the safeguarding authority confirmed they were closing the safeguarding. However, lessons learnt from any safeguarding incidents had not been embedded into the service in order to improve people's care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People were not given the opportunity to be involved in the service, or to give their feedback. One person told us, "I am never asked for feedback and I have never filled in a survey."

● We asked the registered manager whether resident's meetings were held and were told, "Well, as I said, most people living here are not with it." When we pointed out we had spoken with five people already that morning who had full capacity, they said, "The activities lead holds residents' meetings. They will have the

minutes." However, the activities person explained to us, "We used to have them, but COVID came along and we've not had any since."

● People told us the laundry system was not good and although the registered manager was aware of this, action had not been taken to address it. One person told us, "I lose things in the laundry. They don't come back." A relative said, "The one thing that could improve is the laundry. It's not good, clothes go missing" and a second relative told us, "Clothing disappears, and he ends up in somebody else's clothes." They said this had happened on several occasions. Following our inspection, the registered manager told us they had employed a second laundry person to help address this issue.

The above failings evidence a lack of good governance within service and action to improve people's care. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Where incidents, accidents or concerns occurred, relatives were notified, and apologies given. A relative told us, "If anything goes wrong, they will tell me."

● We heard of some positive aspects to the service from some people and relatives about the quality of care at Church View. One person told us, "Staff are lovely. There is nothing that could be better. They know me because I have been here a long time." A second person said, "They [staff] are very good. They look after us well." A third commented, "They have looked after me very well. The staff are absolutely lovely. They are very kind and polite." A relative said, "I've been pleasantly surprised as I was aware of your last report. I always get a positive response from [family member]." A second relative told us, "She is getting good care. Anything they feel she needs; they will ask me."

● We also read of some compliments received at the service. These included, "Lovely to see her quite relaxed and smiling" and (from a social care professional), "I am very pleased with the great progress you have made with working with my client."

● Staff we spoke with on the day told us they felt supported, although we had heard prior to our inspection that staff felt bullied and were frightened to speak up. One staff member said, "Whenever we need some help from management, they are always willing to help us. They are very supportive." A second told us, "I like it here." A third said, "Manager's really support me."

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	There was a lack of person-centred care, end of life care planning and providing activities to meet people's needs.

The enforcement action we took:

We have issued the provider with a warning notice in relation to this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	There was a failure to tackle shortfalls to address risks associated with people.

The enforcement action we took:

We have issued the provider with a warning notice in relation to this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment
Treatment of disease, disorder or injury	There was a lack of understanding by staff on safeguarding processes.

The enforcement action we took:

We have issued the provider with a warning notice in relation to this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	There was a lack of robust governance within the service to ensure people received high quality care.

The enforcement action we took:

We have imposed a condition to the provider's registration in relation to this breach.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There was a failure to suitably deploy enough staff who were competent and properly trained for their role.

The enforcement action we took:

We have issued the provider with a warning notice in relation to this breach.